

103^D CONGRESS
2^D SESSION

S. 2205

To amend the Social Security Act and the Internal Revenue Code of 1986 to provide improved access to quality long-term care services, to obtain cost savings through provider incentives and removal of regulatory and legislative barriers, to encourage greater private sector participation and personal responsibility in financing such services, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 16 (legislative day, JUNE 7), 1994

Mr. HATCH introduced the following bill; which was read the first time

A BILL

To amend the Social Security Act and the Internal Revenue Code of 1986 to provide improved access to quality long-term care services, to obtain cost savings through provider incentives and removal of regulatory and legislative barriers, to encourage greater private sector participation and personal responsibility in financing such services, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Quality Care For Life Act of 1994”.

1 (b) TABLE OF CONTENTS.—The table of contents of
 2 this Act is as follows:

- Sec. 1. Short title; table of contents.
 Sec. 2. Purposes.

TITLE I—PROSPECTIVE PAYMENT SYSTEM FOR NURSING
 FACILITIES

- Sec. 100. Short title.
 Sec. 101. Definitions.
 Sec. 102. Payment objectives.
 Sec. 103. Powers and duties of the Secretary.
 Sec. 104. Relationship to title XVIII of the Social Security Act.
 Sec. 105. Establishment of resident classification system.
 Sec. 106. Cost centers for nursing facility payment.
 Sec. 107. Resident assessment.
 Sec. 108. The per diem rate for nursing service costs.
 Sec. 109. The per diem rate for administrative and general costs.
 Sec. 110. Payment for fee-for-service ancillary services.
 Sec. 111. Reimbursement of selected ancillary services and other costs.
 Sec. 112. The per diem rate for property costs.
 Sec. 113. Mid-year rate adjustments.
 Sec. 114. Exception to payment methods for new and low-volume nursing facilities.
 Sec. 115. Appeal procedures.
 Sec. 116. Effective date.

TITLE II—SUBACUTE CARE CONTINUUM AMENDMENTS OF 1994

- Sec. 200. Short title.
 Sec. 201. Findings and purposes.
 Sec. 202. Creation of a “level playing field” to encourage the development of subacute care providers.
 Sec. 203. Exception process from medicare routine cost limits.
 Sec. 204. Physician visits and consultations for medicare patients in skilled nursing facilities.
 Sec. 205. Coverage of respiratory therapy services in skilled nursing facilities under the medicare program.
 Sec. 206. DRGS appropriate for subacute care in skilled nursing facilities.
 Sec. 207. Subacute care services under title XIX.
 Sec. 208. Effective date.

TITLE III—LONG-TERM CARE TAX CLARIFICATION

- Sec. 301. Short title.
 Sec. 302. Treatment of long-term care insurance or plans.
 Sec. 303. Qualified long-term services treated as medical care.
 Sec. 304. Qualified long-term care insurance contracts permitted to be offered in cafeteria plans.
 Sec. 305. Inclusion in income of excessive long-term care benefits.
 Sec. 306. Tax reserves for qualified long-term care insurance contracts.
 Sec. 307. Effective date.

TITLE IV—LONG-TERM CARE INSURANCE STANDARDS

- Sec. 400. Short title.
- Sec. 401. National Long-Term Care Insurance Advisory Council.
- Sec. 402. Policy requirements.
- Sec. 403. Additional requirements for issuers of long-term care insurance policies.
- Sec. 404. Relation to State law.
- Sec. 405. Uniform language and definitions.
- Sec. 406. Effective dates.

TITLE V—FINANCIAL ELIGIBILITY STANDARDS

- Sec. 501. Revisions to financial eligibility provisions.
- Sec. 502. Effective date.

TITLE VI—ESTABLISHMENT OF PROGRAM FOR HOME AND COMMUNITY-BASED SERVICES FOR CERTAIN INDIVIDUALS WITH DISABILITIES

- Sec. 600. Short title.
- Sec. 601. Establishment of program.
- Sec. 602. Increased resource disregards for nursing facility residents.

TITLE VII—ASSET TRANSFERS

- Sec. 701. Transfers of assets.
- Sec. 702. Treatment of certain trusts.
- Sec. 703. Effective date.

1 **SEC. 2. PURPOSES.**

2 The purposes of this Act are to—

3 (1) enact a prospective payment system for
 4 nursing facility services under all Federal health
 5 care programs that promotes quality care, assures
 6 equal access for all residents regardless of level of
 7 service needed, maintains adequate capital forma-
 8 tion, provides for efficiency incentives for providers,
 9 and contains costs;

10 (2) encourage the use of cost-effective subacute
 11 care in nursing facilities by providing equitable reim-
 12 bursement under all appropriate Federal health care

1 programs and by eliminating regulatory and legisla-
2 tive barriers to providing such care;

3 (3) amend the Internal Revenue Code of 1986
4 to clarify the Federal tax treatment of long term
5 care insurance policies to promote the purchase of
6 such policies;

7 (4) amend the Internal Revenue Code of 1986
8 to develop reasonable Federal standards for long
9 term care insurance that promote consumer protec-
10 tion;

11 (5) modify financial eligibility standards under
12 the medicaid program to ensure an inclusive ac-
13 counting of individual assets and promote personal
14 responsibility for long term care expenses;

15 (6) establish a program for home and commu-
16 nity-based services for individuals with disabilities
17 under the medicaid program to provide beneficiaries,
18 whose needs would be determined by functional eligi-
19 bility standards, with expanded choice of services
20 within a continuum of care, and contain costs by en-
21 couraging the use of appropriate levels of care; and

22 (7) revise the transfer of asset prohibitions
23 under the medicaid program to make the 60-month
24 look-back period in the case of trusts applicable to
25 all transfers of assets, to require “income cap

1 trusts” and “nonprofit association trusts” to be ir-
2 revocable, to include the conversion of personal or
3 real property into annuities as an unlawful transfer,
4 and to direct the Secretary, by regulation, to close
5 such other loopholes not covered by the Omnibus
6 Budget Reconciliation Act of 1993 (Public Law
7 103–66).

8 **TITLE I—PROSPECTIVE PAY-**
9 **MENT SYSTEM FOR NURSING**
10 **FACILITIES**

11 **SEC. 100. SHORT TITLE.**

12 This title may be cited as the “Prospective Payment
13 System for Nursing Facilities Amendments of 1994”.

14 **SEC. 101. DEFINITIONS.**

15 For purposes of this title:

16 (1) “Acuity payment” means a fixed amount
17 that will be added to the facility-specific prices for
18 certain resident classes designated by the Secretary
19 as requiring heavy care.

20 (2) “Aggregated resident invoice” means a com-
21 pilation of the per resident invoices of a nursing fa-
22 cility which contain the number of resident days for
23 each resident and the resident class of each resident
24 at the nursing facility during a particular month.

1 (3) “Allowable costs” means costs which HCFA
2 has determined to be necessary for a nursing facility
3 to incur according to the Provider Reimbursement
4 Manual (hereinafter referred to as “HCFA-Pub.
5 15”).

6 (4) “Base year” means the most recent cost re-
7 porting period (consisting of a period which is 12
8 months in length, except for facilities with new own-
9 ers, in which case the period is not less than 4
10 months nor more than 13 months) for which cost
11 data of nursing facilities is available to be used for
12 the determination of a prospective rate.

13 (5) “Case mix weight” means the total case mix
14 score of a facility calculated by multiplying the resi-
15 dent days in each resident class by the relative
16 weight assigned to each resident class, and summing
17 the resulting products across all resident classes.

18 (6) “Complex medical equipment” means items
19 such as ventilators, intermittent positive pressure
20 breathing (IPPB) machines, nebulizers, suction
21 pumps, continuous positive airway pressure (CPAP)
22 devices, and bead beds such as air fluidized beds.

23 (7) “Distinct part nursing facility” means an
24 institution which has a distinct part that is certified
25 under title XVIII of the Social Security Act and

1 meets the requirements of section 201.1 of the
2 Skilled Nursing Facility Manual published by HCFA
3 (hereinafter referred to as "HCFA-Pub. 12").

4 (8) "Efficiency incentive" means a payment
5 made to a nursing facility in recognition of incurring
6 costs below a prespecified level.

7 (9) "Fixed equipment" means equipment which
8 meets the definition of building equipment in section
9 104.3 of HCFA-Pub. 15. "Fixed equipment" in-
10 cludes, but is not limited to, attachments to build-
11 ings such as wiring, electrical fixtures, plumbing,
12 elevators, heating systems, and air conditioning sys-
13 tems.

14 (10) "Geographic ceiling" means a limitation
15 on payments in any given cost center for nursing fa-
16 cilities in one of no fewer than 8 geographic regions,
17 further subdivided into rural and urban areas, as
18 designated by the Secretary.

19 (11) "Heavy care" means an exceptionally high
20 level of care which the Secretary has determined is
21 required for residents in certain resident classes.

22 (12) "HCFA" means the Health Care Financ-
23 ing Administration of the Department of Health and
24 Human Services.

1 (13) “Indexed forward” means an adjustment
2 made to a per diem rate to account for cost in-
3 creases due to inflation or other factors during an
4 intervening period following the base year and pro-
5 jecting such cost increases for a future period in
6 which the rate applies. Indexing forward under this
7 title shall be determined from the midpoint of the
8 base year to the midpoint of the rate year.

9 (14) “Marshall Swift segmented cost method”
10 means an appraisal method published by the Mar-
11 shall Swift Valuation Service.

12 (15) “Minimum Data Set (hereinafter referred
13 to as ‘MDS’)” means a resident assessment instru-
14 ment, currently recognized by HCFA, in addition to
15 any extensions to MDS, such as MDSs, as well as
16 any extensions to accommodate subacute care which
17 contain an appropriate core of assessment items
18 with definitions and coding categories needed to
19 comprehensively assess a nursing facility resident.

20 (16) “Major movable equipment” means equip-
21 ment which meets the definition of major movable
22 equipment in section 104.4 of HCFA-Pub. 15.
23 “Major movable equipment” includes, but is not lim-
24 ited to, accounting machines, beds, wheelchairs,
25 desks, vehicles, and X-ray machines.

1 (17) “Nursing facility” means an institution
2 which meets the requirements of a “skilled nursing
3 facility” under section 1819(a) of the Social Security
4 Act (42 U.S.C. 1395i-3(a)) and a “nursing facility”
5 under section 1919(a) of the Social Security Act (42
6 U.S.C. 1396r(a)).

7 (18) “Per bed limit” means a per bed ceiling on
8 the fair asset value of a nursing facility for one of
9 the geographic regions designated by the Secretary.

10 (19) “Per diem rate” means a rate of payment
11 for the costs of covered services for a resident day.

12 (20) “Relative weight” means the index of the
13 value of the resources required for a given resident
14 class relative to the value of resources of either a
15 base resident class or the average of all the resident
16 classes.

17 (21) “R. S. Means Index” means the index of
18 the R. S. Means Company, Inc., specific to commer-
19 cial/industrial institutionalized nursing facilities,
20 which is based upon a survey of prices of common
21 building materials and wage rates for nursing facil-
22 ity construction.

23 (22) “Rebase” means the process of updating
24 nursing facility cost data for a subsequent rate year
25 using a more recent base year.

1 (23) “Rental rate” means a percentage that
2 will be multiplied by the fair asset value of property
3 to determine the total annual rental payment in lieu
4 of property costs.

5 (24) “Resident classification system” means a
6 system which categorizes residents into different
7 resident classes according to similarity of the
8 assessed condition and required services of such
9 residents.

10 (25) “Resident day” means the period of serv-
11 ices for one resident, regardless of payment source,
12 for one continuous 24 hours of services. The day of
13 admission of the resident constitutes a resident day
14 but the day of discharge does not constitute a resi-
15 dent day. Bed hold days are not to be considered
16 resident days, and bed hold day revenues are not to
17 be offset.

18 (26) “Resource Utilization Groups, Version III
19 (hereinafter referred to as ‘RUG-III’)” means a cat-
20 egory-based resident classification system used to
21 classify nursing facility residents into mutually ex-
22 clusive RUG-III groups. Residents in each RUG-III
23 group utilize similar quantities and patterns of
24 resources.

1 (27) “Secretary” means the Secretary of
2 Health and Human Services.

3 **SEC. 102. PAYMENT OBJECTIVES.**

4 (a) Payment rates under the Prospective Payment
5 System for Nursing Facilities shall reflect the following
6 objectives:

7 (1) To maintain an equitable and fair balance
8 between cost containment and quality of care in
9 nursing facilities.

10 (2) To encourage nursing facilities to admit
11 residents without regard to such residents’ source of
12 payment.

13 (3) To provide an incentive to nursing facilities
14 to admit and provide care to persons in need of com-
15 paratively greater care.

16 (4) To maintain administrative simplicity, for
17 both nursing facilities and the Secretary.

18 (5) To encourage investment in buildings and
19 improvements to nursing facilities (capital forma-
20 tion) as necessary to maintain quality and access.

21 **SEC. 103. POWERS AND DUTIES OF THE SECRETARY.**

22 (a) The Secretary shall establish by regulation the
23 implementation of this title. The rates determined under
24 this title shall reflect the objectives in section 102.

1 (b) The Secretary may require that each nursing fa-
2 cility file such data, statistics, schedules, or information
3 as required to enable the Secretary to implement this title.

4 **SEC. 104. RELATIONSHIP TO TITLE XVIII OF THE SOCIAL**
5 **SECURITY ACT.**

6 (a) No provision in this title shall replace, or other-
7 wise affect, the skilled nursing facility benefit under title
8 XVIII of the Social Security Act.

9 (b) The provisions of HCFA-Pub. 15 shall apply to
10 the determination of allowable costs under this title except
11 to the extent that such provisions conflict with any other
12 provision in this title.

13 **SEC. 105. ESTABLISHMENT OF RESIDENT CLASSIFICATION**
14 **SYSTEM.**

15 (a)(1) The Secretary shall establish a resident classi-
16 fication system which shall group residents into classes ac-
17 cording to similarity of the assessed condition and re-
18 quired services of such residents.

19 (2) The resident classification system shall be mod-
20 elled after the RUG-III system and all updated versions
21 of that system.

22 (3) The resident classification system shall be reflec-
23 tive of the necessary professional and paraprofessional
24 nursing staff time and costs required to address the care
25 needs of nursing facility residents.

1 (b)(1) The Secretary shall assign a relative weight for
2 each resident class based on the relative value of the re-
3 sources required for each resident class. The assignment
4 of relative weights for resident classes shall be performed
5 for each geographic region as determined in accordance
6 with subsection (c).

7 (2) In assigning the relative weights of the resident
8 classes in a geographic region, the Secretary shall utilize
9 information derived from the most recent MDSs of all of
10 the nursing facilities in a geographic region.

11 (3) The relative weights of the resident classes in
12 each geographic region shall be recalibrated every 3 years
13 based on any changes in the cost or amount of resources
14 required for the care of a resident in the resident class.

15 (c)(1) The Secretary shall designate no fewer than
16 8 geographic regions for the total United States. Within
17 each geographic region, the Secretary shall take appro-
18 priate account of variations in cost between urban and
19 rural areas.

20 (2) There shall be no peer grouping of nursing facili-
21 ties (e.g., based on whether the nursing facilities are hos-
22 pital-based or not) other than peer-grouping by geographic
23 region.

1 **SEC. 106. COST CENTERS FOR NURSING FACILITY PAY-**
2 **MENT.**

3 (a) Consistent with the objectives established in sec-
4 tion 102, the Secretary shall determine payment rates for
5 nursing facilities using the following cost-service
6 groupings:

7 (1) The nursing service cost center shall include
8 salaries and wages for the Director of Nursing,
9 Quality Assurance Nurses, registered nurses, li-
10 censed practical nurses, nurse aides (including wages
11 related to initial and on-going nurse aide training
12 and other on-going or periodic training costs in-
13 curred by nursing personnel), contract nursing,
14 fringe benefits and payroll taxes associated there-
15 with, medical records, and nursing supplies.

16 (2) The administrative and general cost center
17 shall include all expenses (including salaries, bene-
18 fits, and other costs) related to administration, plant
19 operation, maintenance and repair, housekeeping, di-
20 etary (excluding raw food), central services and sup-
21 ply (excluding medical supplies), laundry, and social
22 services.

23 (3) Ancillary services to be paid on a fee-for-
24 service basis shall include physical therapy, occupa-
25 tional therapy, speech therapy, respiratory therapy,
26 hyperalimentation, and complex medical equipment

1 (CME). These fee-for-service ancillary service pay-
2 ments under Part A of title XVIII of the Social Se-
3 curity Act shall not affect the reimbursement of an-
4 cillary services under part B of title XVIII of the
5 Social Security Act.

6 (4) The cost center for selected ancillary serv-
7 ices and other costs shall include drugs, raw food,
8 medical supplies, IV therapy, X-ray services, labora-
9 tory services, property tax, property insurance,
10 minor equipment, and all other costs not included in
11 the other 4 cost/service groupings.

12 (5) The property cost center shall include de-
13 preciation on the buildings and fixed equipment,
14 major movable equipment, motor vehicles, land im-
15 provements, amortization of leasehold improvements,
16 lease acquisition costs, and capital leases; interest on
17 capital indebtedness; mortgage interest; lease costs;
18 and equipment rental expense.

19 (b) Nursing facilities shall be paid a prospective, fa-
20 cility-specific, per diem rate based on the sum of the per
21 diem rates established for the nursing service, administra-
22 tive and general, and property cost centers as determined
23 in accordance with sections 108, 109, and 112.

24 (c) Nursing facilities shall be paid a facility-specific
25 prospective rate for each unit of the fee-for-service ancil-

1 lary services as determined in accordance with section
2 110.

3 (d) Nursing facilities shall be reimbursed for selected
4 ancillary services and other costs on a retrospective basis
5 in accordance with section 111.

6 **SEC. 107. RESIDENT ASSESSMENT.**

7 (a) The nursing facility shall perform a resident as-
8 sessment in accordance with section 1819(b)(3) of the So-
9 cial Security Act (42 U.S.C. 1395i-3(a)) within 14 days
10 of admission of the resident and at such other times as
11 required by that section.

12 (b) The resident assessment shall be used to deter-
13 mine the resident class of each resident in the nursing fa-
14 cility for purposes of determining the per diem rate for
15 the nursing service cost center in accordance with section
16 108.

17 **SEC. 108. THE PER DIEM RATE FOR NURSING SERVICE**
18 **COSTS.**

19 (a)(1) The nursing service cost center rate shall be
20 calculated using a prospective, facility-specific per diem
21 rate based on the nursing facility's case-mix weight and
22 nursing service costs during the base year.

23 (2) The case-mix weight of a nursing facility shall
24 be obtained by multiplying the number of resident days
25 in each resident class at a nursing facility during the base

1 year by the relative weight assigned to each resident class
2 in the appropriate geographic region. Once this calculation
3 is performed for each resident class in the nursing facility,
4 the sum of these products shall constitute the case-mix
5 weight for the nursing facility.

6 (3) A facility nursing unit value for the nursing facil-
7 ity for the base year shall be obtained by dividing the nurs-
8 ing service costs for the base year, which shall be indexed
9 forward from the midpoint of the base period to the mid-
10 point of the rate period using the DRI McGraw-Hill
11 HCFA Nursing Home Without Capital Market Basket, by
12 the case-mix weight of the nursing facility for the base
13 year.

14 (4) A facility-specific nursing services price for each
15 resident class shall be obtained by multiplying the lower
16 of the indexed facility unit value of the nursing facility
17 during the base year or the geographic ceiling, as deter-
18 mined in accordance with subsection (b), by the relative
19 weight of the resident class.

20 (5) The Secretary shall designate certain resident
21 classes as requiring heavy care. An acuity payment of 3
22 percent of the facility-specific nursing services price shall
23 be added on to the facility-specific price for each resident
24 class which the Secretary has designated as requiring
25 heavy care. The acuity payment is intended to provide an

1 incentive to nursing facilities to admit residents requiring
2 heavy care.

3 (6) The per diem rate for the nursing service cost
4 center for each resident in a resident class shall constitute
5 the facility-specific price, plus the acuity payment where
6 appropriate.

7 (7) The per diem rate for the nursing service cost
8 center, including the facility-specific price and the acuity
9 payment, shall be rebased annually.

10 (8) To determine the payment amount to a nursing
11 facility for the nursing service cost center, the Secretary
12 shall multiply the per diem rate (including the acuity pay-
13 ment) for a resident class by the number of resident days
14 for each resident class based on aggregated resident in-
15 voices which each nursing facility shall submit on a month-
16 ly basis.

17 (b)(1) The facility unit value identified in subsection
18 (a)(3) shall be subjected to geographic ceilings established
19 for the geographic regions designated by the Secretary in
20 section 105(c).

21 (2) The geographic ceiling shall be determined by
22 first creating an array of indexed facility unit values in
23 a geographic region from lowest to highest. Based on this
24 array, the Secretary shall identify a fixed proportion be-
25 tween the indexed facility unit value of the nursing facility

1 which contained the medianth resident day in the array
2 (except as provided in subsection (b)(4)) and the indexed
3 facility unit value of the nursing facility which contained
4 the 95th percentile resident day in that array during the
5 first year of operation of the Prospective Payment System
6 For Nursing Facilities. The fixed proportion (e.g., 1.1
7 times the median or 110 percent of the median) shall re-
8 main the same in subsequent years.

9 (3) To obtain the geographic ceiling on the indexed
10 facility unit value for nursing facilities in a geographic re-
11 gion in each subsequent year, the fixed proportion identi-
12 fied pursuant to subsection (b)(2) shall be multiplied by
13 the indexed facility unit value of the nursing facility which
14 contained the medianth resident day in the array of facil-
15 ity unit values for the geographic region during the base
16 year.

17 (4) The Secretary shall exclude low-volume and new
18 nursing facilities, as defined in subsections (a) and (b) of
19 section 113, respectively, for purposes of determining the
20 geographic ceiling for the nursing service cost center.

21 (c) The Secretary shall establish by regulation, proce-
22 dures for allowing exceptions to the geographic ceiling im-
23 posed on the nursing service cost center. The procedure
24 shall permit exceptions based on the following factors:

1 (1) Local supply and/or labor shortages which
2 substantially increase costs to specific nursing facili-
3 ties.

4 (2) Higher per resident day usage of contract
5 nursing personnel, if utilization of contract nursing
6 personnel is warranted by local circumstances, and
7 the provider has taken all reasonable measures to
8 minimize contract personnel expense.

9 (3) Extraordinarily low proportion of distinct
10 part nursing facilities in a geographic region result-
11 ing in a geographic ceiling which unfairly restricts
12 the reimbursement of distinct part facilities.

13 (4) Regulatory changes that increase costs to
14 only a subset of the nursing facility industry.

15 (5) The offering of a new institutional health
16 service or treatment program by a nursing facility
17 (in order to account for initial start-up costs).

18 (6) Disproportionate usage of part-time employ-
19 ees, where adequate numbers of full-time employees
20 cannot reasonably be obtained.

21 (7) Other cost producing factors, to be specified
22 by the Secretary in regulations that are specific to
23 a subset of facilities in a geographic region (except
24 case-mix variation).

1 **SEC. 109. THE PER DIEM RATE FOR ADMINISTRATIVE AND**
2 **GENERAL COSTS.**

3 (a)(1) Payment relative to the administrative and
4 general cost center shall be a facility-specific, prospective,
5 per diem rate.

6 (2) The Secretary shall assign a per diem rate to a
7 nursing facility by applying 2 standards which shall be cal-
8 culated as follows:

9 (A) Standard A shall be derived for each geo-
10 graphic region by first creating an array of indexed
11 nursing facility administrative and general per diem
12 costs from lowest to highest. The Secretary shall
13 then identify a fixed proportion by dividing the in-
14 dexed administrative and general per diem costs of
15 the nursing facility which contained the medianth
16 resident day of the array (except as provided in sub-
17 section (a)(4)) into the indexed administrative and
18 general per diem costs of the nursing facility which
19 contained the 75th percentile resident day in that
20 array. Standard A for each base year shall con-
21 stitute the product of this fixed proportion (e.g., 1.1
22 times the median or 110 percent of the median) and
23 the administrative and general indexed per diem
24 costs of the nursing facility which contained the
25 medianth resident day in the array of such costs
26 during the base year.

1 (B) Standard B shall be derived using the same
2 calculation as in subparagraph (A) except that the
3 fixed proportion shall use the indexed administrative
4 and general costs of the nursing facility containing
5 the 85th percentile, rather than the 75th percentile,
6 resident day in the array of such costs.

7 (3) The Secretary shall use the geographic regions
8 identified in section 105(c) for purposes of determining
9 Standard A and Standard B.

10 (4) The Secretary shall exclude low-volume and new
11 nursing facilities, as defined in subsections (a) and (b) of
12 section 113, respectively, for purposes of determining
13 Standard A and Standard B.

14 (5) To determine a nursing facility's per diem rate
15 for the administrative and general cost center, Standard
16 A and Standard B shall be applied to a nursing facility's
17 administrative and general per diem costs, indexed for-
18 ward using the DRI McGraw-Hill HCFA Nursing Home
19 Without Capital Market Basket, as follows:

20 (A) Each nursing facility having indexed costs
21 which fall below the median shall be assigned a rate
22 equal to such facility's individual indexed costs plus
23 an "efficiency incentive" equal to one half of the dif-
24 ference between the median and Standard A.

1 (B) Each nursing facility having indexed costs
2 which fall below Standard A but at or above the me-
3 dian shall be assigned a per diem rate equal to such
4 facility's individual indexed costs plus an "efficiency
5 incentive" equal to one-half of the difference be-
6 tween such facility's indexed costs and Standard A.

7 (C) Each nursing facility having indexed costs
8 which fall between Standard A and Standard B shall
9 be assigned a rate equal to Standard A plus one-half
10 of the difference between such facility's indexed
11 costs and Standard A.

12 (D) Each nursing facility having indexed costs
13 which exceed Standard B shall be assigned a rate as
14 if such facility's costs equaled Standard B. These
15 nursing facilities shall be assigned a per diem rate
16 equal to Standard A plus one-half of the difference
17 between Standard A and Standard B.

18 (E) For purposes of subparagraphs (A) through
19 (D), the median represents the indexed administra-
20 tive and general per diem costs of the nursing facil-
21 ity which contained the medianth resident day in the
22 array of such costs during the base year in the geo-
23 graphic region.

1 (b) Rebasing of the payment rates for administrative
2 and general costs shall occur no less frequently than once
3 a year.

4 **SEC. 110. PAYMENT FOR FEE-FOR-SERVICE ANCILLARY**
5 **SERVICES.**

6 (a) Payment for each ancillary service enumerated in
7 section 106(a)(3), such as physical therapy, shall be cal-
8 culated and paid on a prospective fee-for-service basis.

9 (b) The Secretary shall identify the fee for each of
10 the fee-for-service ancillary services for a particular nurs-
11 ing facility by dividing the nursing facility's actual costs,
12 including overhead allocated through the cost finding proc-
13 ess, of providing each particular service, indexed forward
14 using the DRI McGraw-Hill HCFA Nursing Home With-
15 out Capital Market Basket, by the units of the particular
16 service provided by the nursing facility during the cost
17 year.

18 (c) The fee for each of the fee-for-service ancillary
19 services shall be calculated at least once a year for each
20 facility and ancillary service.

21 **SEC. 111. REIMBURSEMENT OF SELECTED ANCILLARY**
22 **SERVICES AND OTHER COSTS.**

23 (a) Reimbursement of selected ancillary services and
24 other costs identified in section 106(a)(4), such as drugs
25 and medical supplies, shall be reimbursed on a retrospec-

1 tive basis as pass-through costs, including overhead allo-
2 cated through the cost-finding process.

3 (b) The Secretary shall set charge-based interim rates
4 for selected ancillary services and other costs for each
5 nursing facility providing such services. Any overpayments
6 or underpayments resulting from the difference between
7 the interim and final settlement rates shall be either re-
8 funded by the nursing facility or paid to the nursing facil-
9 ity following submission of a timely filed medicare cost
10 report.

11 **SEC. 112. THE PER DIEM RATE FOR PROPERTY COSTS.**

12 (a)(1) The basis for payment within the property cost
13 center for nursing facilities shall be calculated and paid
14 on a prospective (except as provided for newly constructed
15 facilities in subsection (d)(2)), facility-specific, per resi-
16 dent day rate based on the fair asset value of the property.

17 (2)(A) The fair asset value of the property shall con-
18 stitute the sum of the market value of the land (including
19 site preparation costs), a reconstruction cost appraised
20 value for the buildings and fixed equipment, and the prod-
21 uct of the number of beds in the nursing facility and a
22 per bed allowance for major movable equipment.

23 (B) The land, buildings, and fixed equipment which
24 are included in determining the fair asset value must be
25 used in connection with the care of residents.

1 (C) Appraisals for the buildings and fixed equipment
2 shall be performed using the Marshall-Swift segmented
3 cost method. A nursing facility shall be appraised every
4 4 years.

5 (D) The Secretary shall utilize an annual allowance
6 of \$3,500 per bed for major movable equipment for a
7 nursing facility. The Secretary shall review the annual al-
8 lowance for major movable equipment every 5 years to de-
9 termine its accuracy.

10 (E) If a nursing facility has commenced a renovation
11 to a building and fixed equipment between appraisals the
12 cost of which constitutes at least 5 percent of the total
13 value of the existing building and the fixed equipment,
14 such facility may submit documentation as to the cost of
15 the renovation during the previous year. The Secretary
16 shall add the reasonable costs of the major renovation for
17 the previous year to the fair asset value of the facility.
18 This new asset value is to be the base for indexing until
19 the next full appraisal.

20 (F) The value of the assets is determined through
21 appraisals, indexing, and the application of allowances,
22 and is, therefore, unaffected by sales transactions, re-fi-
23 nancing, or other changes in financing. Accordingly, the
24 concept of recapture of depreciation is inapplicable to fa-
25 cilities whose payment is established under this title.

1 (3) The value of the land, buildings, and fixed equip-
2 ment shall be indexed annually between reappraisals as
3 follows:

4 (A) The land shall be indexed using Consumer
5 Price Index Urban.

6 (B) The buildings and fixed equipment shall be
7 indexed annually using the R. S. Means Index.

8 (4) The annual allowance for major movable equip-
9 ment shall be indexed annually using the hospital equip-
10 ment index of the Marshall Swift Valuation Service.

11 (5) The Secretary shall adjust the indexes used for
12 the land, buildings and fixed equipment, and major mov-
13 able equipment for the different geographic regions.

14 (b)(1) The Secretary shall establish a per bed limit
15 on the fair asset value of a nursing facility for each geo-
16 graphic region, as designated in section 105(c). The per
17 bed limit shall be equal to the average indexed costs in-
18 curred by all recently constructed nursing facilities in the
19 geographic region which have been designed and con-
20 structed in an efficient manner.

21 (2) The per bed limit on the fair asset value shall
22 be indexed annually using the R. S. Means Index.

23 (3) The per bed limit shall be recalculated every 5
24 years.

1 (c) The total annual rental shall constitute the prod-
2 uct of the lower of the indexed fair asset value or the in-
3 dexed per bed limit and a rental rate which shall be based
4 on the average yield for 20 year United States Treasury
5 Bonds during the prior year plus a risk premium of 3 per-
6 centage points.

7 (d)(1) The per resident day rental shall be obtained
8 by dividing the total annual rental by 90 percent of the
9 annual licensed bed days. The per resident day rental shall
10 constitute the per diem rate attributable to the property
11 cost center.

12 (2) The per resident day rental rate for a newly-con-
13 structed facility during such facility's first year of oper-
14 ation shall be based on the total annual rental divided by
15 the greater of 50 percent of available resident days or ac-
16 tual annualized resident days up to 90 percent of annual
17 licensed bed days during such facility's first year of oper-
18 ation.

19 (e) Facilities in operation prior to the effective date
20 of this title shall receive the per resident day rental or
21 actual costs, as determined in accordance with HCFA-
22 Pub. 15, whichever is greater, except that a nursing facil-
23 ity shall be reimbursed the per resident day rental on and
24 after the earlier of—

1 (1) the date upon which the nursing facility
2 changes ownership;

3 (2) the date the nursing facility accepts the per
4 resident day rental; or

5 (3) the date of the renegotiation of the lease for
6 the land and/or buildings, not including the exercise
7 of optional extensions specifically included in the
8 original lease agreement or valid extensions thereof.

9 **SEC. 113. MID-YEAR RATE ADJUSTMENTS.**

10 (a)(1) The Secretary shall establish by regulation, a
11 procedure for granting mid-year rate adjustments for the
12 nursing service, administrative and general, and fee-for-
13 service ancillary services cost centers.

14 (2) The mid-year rate adjustment procedure shall re-
15 quire the Secretary to grant adjustments on an industry-
16 wide basis, without the need for nursing facilities to apply
17 for such adjustments, based on the following cir-
18 cumstances:

19 (A) Statutory or regulatory changes affecting
20 nursing facilities (e.g., new staffing standards or ex-
21 panded services).

22 (B) Changes to the Federal minimum wage.

23 (C) General labor shortages with high regional
24 wage impacts.

1 (3) The midyear rate adjustment procedure shall per-
2 mit specific facilities or groups of facilities to apply for
3 an adjustment based on the following factors:

4 (A) Local labor shortages.

5 (B) Regulatory changes that apply to only a
6 subset of the nursing facility industry.

7 (C) Economic conditions created by natural dis-
8 asters or other events outside of the control of the
9 provider.

10 (D) Other cost producing factors, except case-
11 mix variation, to be specified by the Secretary by
12 regulation.

13 (4)(A) A nursing facility which applies for a mid-year
14 rate adjustment pursuant to subsection (a)(3) shall be re-
15 quired to show that the adjustment will result in a greater
16 than 2 percent deviation in the per diem rate for any indi-
17 vidual cost service center or a deviation of greater than
18 \$5,000 in the total projected and indexed costs for the
19 rate year, whichever is less.

20 (B) A nursing facility application for a midyear rate
21 adjustment must be accompanied by recent cost experi-
22 ence data and/or budget projections.

1 **SEC. 114. EXCEPTION TO PAYMENT METHODS FOR NEW**
2 **AND LOW-VOLUME NURSING FACILITIES.**

3 (a) A low-volume nursing facility shall constitute a
4 nursing facility having fewer than 2,500 medicare part A
5 resident days per year.

6 (b) A new nursing facility shall constitute a newly
7 constructed, licensed, and certified nursing facility and/or
8 a nursing facility that is in its first 3 years of operation
9 as a medicare part A provider. A nursing facility that has
10 operated for more than 3 years but has a change of owner-
11 ship shall not constitute a new facility.

12 (c) Low-volume nursing facilities shall have the op-
13 tion of submitting a cost report to receive retrospective
14 payment for all of the cost centers, other than the property
15 cost center, or accepting a per diem rate which shall be
16 based on the sum of—

17 (1) the median indexed resident day facility
18 unit value for the appropriate geographic region for
19 the nursing service cost center during the base year
20 as identified in section 108(b)(2),

21 (2) the median indexed resident day administra-
22 tive and general per diem costs of all nursing facili-
23 ties in the appropriate geographic region as identi-
24 fied in section 109(a)(5)(E),

25 (3) the median indexed resident day costs per
26 unit of service for fee-for-service ancillary services

1 which shall be obtained using the cost information
2 from the nursing facilities in the appropriate geo-
3 graphic region during the base year, excluding low-
4 volume and new nursing facilities, and which shall
5 be based on an array of such costs from lowest to
6 highest, and

7 (4) the median indexed resident day per diem
8 costs for selected ancillary services and other costs
9 which shall be obtained using information from the
10 nursing facilities in the appropriate geographic re-
11 gion during the base year, excluding low-volume and
12 new nursing facilities, and which shall be based on
13 an array of such costs from lowest to highest.

14 (d) New nursing facilities shall have the option of
15 being paid on a retrospective cost pass-through basis for
16 all cost centers, or in accordance with paragraphs (1)
17 through (4) of subsection (c).

18 **SEC. 115. APPEAL PROCEDURES.**

19 (a)(1) Any person or legal entity aggrieved by a deci-
20 sion of the Secretary under this title, and which results
21 in an amount in controversy of \$10,000 or more, shall
22 have the right to appeal such decision directly to the Pro-
23 vider Reimbursement Review Board (hereinafter referred
24 to as the "Board") authorized under section 1878 of title
25 XVIII of the Social Security Act.

1 (2) The \$10,000 amount in controversy shall be com-
2 puted in accordance with 42 C.F.R. 405.1839.

3 (b) Hearings before the Board under this title, and
4 any appeals thereto, shall follow the procedures under sec-
5 tion 1878 of title XVIII of the Social Security Act and
6 the regulations contained in 42 C.F.R. 405.1841–1889,
7 except to the extent that such procedures conflict with,
8 or are inapplicable on account of, any other provision of
9 this title.

10 **SEC. 116. EFFECTIVE DATE.**

11 (a) The provisions of this title shall be effective Octo-
12 ber 1, 1995.

13 (b) The provisions contained in this title shall
14 supercede any other provisions of title XVIII or title XIX
15 of the Social Security Act which are inconsistent with such
16 provisions.

17 **TITLE II—SUBACUTE CARE CON-**
18 **TINUUM AMENDMENTS OF**
19 **1994**

20 **SEC. 200. SHORT TITLE.**

21 This title may be cited as the “Subacute Care Contin-
22 uum Act of 1994”.

23 **SEC. 201. FINDINGS AND PURPOSES.**

24 (a) This title is based on the following findings:

1 (1) The Federal Government currently bears
2 excessive costs in providing subacute care to patients
3 for whom inpatient hospital services are not medi-
4 cally necessary, in part because of difficulties in
5 placing such patients in nursing facilities.

6 (2) Nursing facilities are currently disadvan-
7 taged in providing subacute care services because of
8 the significant cash flow burdens resulting from
9 delays by the Health Care Financing Administration
10 in approving exceptions from the medicare routine
11 cost limits.

12 (3) Physicians are discouraged from facilitating
13 the placement of subacute care patients into skilled
14 nursing facilities because of the absence of equal re-
15 imbursement for equivalent medically-necessary phy-
16 sician visits, regardless of setting.

17 (4) Current restrictions on payment for res-
18 piratory therapy provided in skilled nursing facilities
19 discourage the admission of subacute care patients
20 who will require such therapy services.

21 (5) The provision of subacute care by skilled
22 nursing facilities and nursing facilities can result in
23 increased efficiency and substantial cost savings to
24 the medicare and medicaid programs.

1 (b) The purposes of this title, among others, are to
2 remove existing and potential statutory and regulatory
3 barriers to the provision of quality, cost-effective subacute
4 care by skilled nursing facilities and nursing facilities
5 under titles XVIII and XIX of the Social Security Act,
6 and to alleviate the present cash flow burdens for skilled
7 nursing facilities that provide such care.

8 **SEC. 202. CREATION OF A “LEVEL PLAYING FIELD” TO EN-**
9 **COURAGE THE DEVELOPMENT OF SUBACUTE**
10 **CARE PROVIDERS.**

11 (a)(1) Section 1819(a) of the Social Security Act (42
12 U.S.C. 1395i-3(a)) is amended by adding at the end the
13 following new flush sentences:

14 “Nothing in this title shall be construed to prohibit, or
15 otherwise limit, a skilled nursing facility from offering or
16 providing subacute care services. Any requirements relat-
17 ing to the provision of such services as may be prescribed
18 by the Secretary or the States shall not include any term
19 or condition forbidding, or otherwise limiting, such facility
20 from so qualifying based on its status as a skilled nursing
21 facility. As used in this subsection, a patient needing
22 ‘subacute care services’ has had an acute event as a result
23 of an illness, injury, or exacerbation of a disease process;
24 has a determined course of treatment; does not require
25 intensive diagnostic or invasive procedures; and has a se-

1 vere condition requiring an outcome-focused, interdiscipli-
2 nary approach utilizing a professional team to deliver com-
3 plex clinical interventions (medical or rehabilitative or
4 both) and a higher frequency of physical visits than tradi-
5 tional extended or skilled nursing care.”.

6 (2) Section 1861(v)(1)(E) of the Social Security Act
7 (42 U.S.C. 1395x(v) (1)(E)) is amended by inserting “,
8 including subacute care services furnished by such facili-
9 ties” in the first sentence after “services” the second place
10 it appears.

11 (3) Section 1888(c) of the Social Security Act (42
12 U.S.C. 1395yy(c)) is amended by inserting “(including,
13 but not limited to, the provision of subacute care services
14 by such facility)” after “case mix”.

15 (4) The amendments made by this subsection shall
16 be effective on the date of the enactment of this Act.

17 (b)(1) Section 1919(a) of the Social Security Act (42
18 U.S.C. 1396r(a)) is amended by inserting after the last
19 sentence the following new sentences: “Nothing in this
20 title shall be construed to prohibit, or otherwise limit, a
21 skilled nursing facility from offering or providing subacute
22 care services. Any requirements relating to the provision
23 of such services as may be prescribed by the Secretary
24 or the States shall not include any term or condition for-
25 bidding, or otherwise limiting, such facility from so quali-

1 fying based on its status as a skilled nursing facility. As
2 used in this subsection, a patient needing ‘subacute care
3 services’ has had an acute event as a result of an illness,
4 injury, or exacerbation of a disease process; has a deter-
5 mined course of treatment; does not require intensive di-
6 agnostic or invasive procedures; and has a severe condition
7 requiring an outcome-focused, interdisciplinary approach
8 utilizing a professional team to deliver complex clinical
9 interventions (medical or rehabilitative or both) and a
10 higher frequency of physical visits than traditional nursing
11 facility care.”.

12 (2) Section 1902(a)(13)(A) of the Social Security Act
13 (42 U.S.C. 1396a(a)(13)(A)) is amended—

14 (A) by inserting “, subacute care services fur-
15 nished by a nursing facility” after “nursing facility
16 services” ; and

17 (B) by inserting “nursing facility furnishing
18 subacute care services,” after “the filing of uniform
19 cost reports by each hospital, nursing facility,”.

20 (3) The amendments made by this subsection shall
21 be effective on the date of the enactment of this Act.

1 **SEC. 203. EXCEPTION PROCESS FROM MEDICARE ROUTINE**
2 **COST LIMITS.**

3 (a) Section 1888 of the Social Security Act (42
4 U.S.C. 1395yy) is amended by adding at the end the fol-
5 lowing new subsection:

6 “(e) Effective January 1, 1996, regardless of the is-
7 suance of final regulations, with respect to any limits on
8 the reasonable costs of providing subacute care services,
9 the Secretary shall grant any skilled nursing facility pro-
10 viding subacute care services an interim exception within
11 90 days of submission of a request for such exception, sub-
12 ject to such procedures and accompanied by such data and
13 such documentation as the Secretary shall determine by
14 regulation. The Secretary shall finalize such interim ex-
15 ception based upon settled data at the end of the applica-
16 ble cost reporting period. Upon finalization of the excep-
17 tion request, the Secretary shall be responsible for reim-
18 bursement of any underpayment, and the skilled nursing
19 facility shall be responsible for reimbursement of any over-
20 payment within 30 days of such finalization, subject to
21 such guarantees as the Secretary shall determine by regu-
22 lation.”.

23 (b) Notwithstanding any other provision of, or
24 amendment made by this title, a nursing facility that has
25 obtained an exception from the routine cost limits for pro-
26 viding subacute care under section 1888(e) of the Social

1 Security Act (as added by subsection (a)), before the effec-
2 tive date specified by section 208(b), shall have the option
3 of continuing to receive payments in accordance with such
4 exception for not more than 12 months after such date.

5 **SEC. 204. PHYSICIAN VISITS AND CONSULTATIONS FOR**
6 **MEDICARE PATIENTS IN SKILLED NURSING**
7 **FACILITIES.**

8 Section 1848(b) of the Social Security Act (42 U.S.C.
9 1395w-4(b)) is amended by—

10 (1) redesignating paragraphs (2) and (3) as
11 paragraphs (3) and (4), respectively; and

12 (2) inserting after paragraph (1) the following
13 new paragraph:

14 “(2) TREATMENT OF PHYSICIAN VISITS TO
15 SUBACUTE CARE PATIENT IN A SKILLED NURSING
16 FACILITY.—Before January 1 of each year (begin-
17 ning in 1996 and regardless of the issuance of final
18 regulations), the Secretary shall establish by regula-
19 tion, fee schedules that establish amounts for physi-
20 cian visits to a subacute care patient in a skilled
21 nursing facility that shall be the same as if the phy-
22 sician visited such subacute care patient in a hos-
23 pital.”

1 **SEC. 205. COVERAGE OF RESPIRATORY THERAPY SERVICES**
2 **IN SKILLED NURSING FACILITIES UNDER**
3 **THE MEDICARE PROGRAM.**

4 (a) Section 1861(h)(3) of the Social Security Act (42
5 U.S.C. 1395x(h)) is amended by inserting “respiratory,”
6 after “occupational,”.

7 (b) Section 1861(v)(5)(A) of the Social Security Act
8 (42 U.S.C. 1395x(v)(5)(A)) is amended by inserting
9 “(other than respiratory therapy services)” after “other
10 therapy services”.

11 **SEC. 206. DRGS APPROPRIATE FOR SUBACUTE CARE IN**
12 **SKILLED NURSING FACILITIES.**

13 (a) Not later than October 1, 1995, the Secretary
14 shall review the provision of subacute care by skilled nurs-
15 ing facilities and determine which hospital DRGs are ap-
16 propriate for skilled nursing facilities that provide such
17 care, and the appropriate hospitalizations and co-pay-
18 ments for such DRGs.

19 (b) Not later than October 1, 1996, the Secretary
20 shall publish a list of applicable DRGs with appropriate
21 hospitalizations and co-payments, and rebase medicare
22 payments for such groups to reflect the lower cost of such
23 care provided in skilled nursing facilities.

24 **SEC. 207. SUBACUTE CARE SERVICES UNDER TITLE XIX.**

25 (a) It is sense of the Congress that States are encour-
26 aged to develop payment methodologies under section

1 1901(a)(13) of the Social Security Act (42 U.S.C.
2 1396a(a)(13)), for nursing facilities which provide
3 subacute care to medicaid patients.

4 (b) It is the sense of the Congress that Federal fund-
5 ing should be available for nursing facilities which provide
6 subacute care to medicaid patients.

7 **SEC. 208. EFFECTIVE DATE.**

8 (a) Except as otherwise provided under this title and
9 subsection (b), the provisions of, and the amendments
10 made by, this title shall be effective January 1, 1996.

11 (b) Subacute classifications established under the
12 provisions of, and amendments made by, this title shall
13 be effective not later than October 1, 1996.

14 **TITLE III—LONG-TERM CARE**
15 **TAX CLARIFICATION**

16 **SEC. 301. SHORT TITLE.**

17 This title may be cited as the “Private Long-Term
18 Care Insurance Incentive Amendments of 1994”.

19 **SEC. 302. TREATMENT OF LONG-TERM CARE INSURANCE**
20 **OR PLANS.**

21 (a) Chapter 79 of the Internal Revenue Code of 1986
22 (relating to definitions) is amended by inserting after sec-
23 tion 7702A the following new section:

1 **“SEC. 7702B. TREATMENT OF LONG-TERM CARE INSURANCE**
2 **OR PLANS.**

3 “(a) GENERAL RULE.—For purposes of this title—

4 “(1) a qualified long-term care insurance con-
5 tract shall be treated as an accident or health insur-
6 ance contract,

7 “(2) any plan of an employer providing cov-
8 erage of qualified long-term care services shall be
9 treated as an accident or health plan with respect to
10 such services,

11 “(3) amounts received under such a contract or
12 plan with respect to qualified long-term care serv-
13 ices, including payments described in subsection
14 (b)(2)(A), shall be treated—

15 “(A) as amounts received for personal in-
16 juries or sickness, and

17 “(B) for purposes of section 105(c), as
18 amounts received for the permanent loss of a
19 function of the body, and as amounts computed
20 with reference to the nature of the injury, and

21 “(4) payments described in subsection (b)(2)(A)
22 shall be treated as payments made with respect to
23 qualified long-term care services.

24 Paragraph (3)(B) shall not apply in the case of amounts
25 attributable to (and not in excess of) deductions allowed
26 under section 213 (relating to medical etc., expenses) for

1 any prior taxable year and also shall not apply for pur-
2 poses of section 105(f).

3 “(b) QUALIFIED LONG-TERM CARE INSURANCE
4 CONTRACT.—

5 “(1) IN GENERAL.—For purposes of this title,
6 the term ‘qualified long-term care insurance con-
7 tract’ means any insurance contract if—

8 “(A) the only insurance protection pro-
9 vided under such contract is coverage of quali-
10 fied long-term care services and benefits inci-
11 dental to such coverage,

12 “(B) such contract or coverage is guaran-
13 teed renewable, or in the case of a group certifi-
14 cate, provides the insured individual with a
15 basis for continuation or conversion of coverage,

16 “(C) such contract does not have any cash
17 surrender value, and

18 “(D) all refunds of premiums, and all pol-
19 icyholder dividends or similar amounts, under
20 such contract are to be applied as a reduction
21 in future premiums or to increase future bene-
22 fits.

23 “(2) SPECIAL RULES.—

24 “(A) PER DIEM, ETC. PAYMENTS PER-
25 MITTED.—A contract shall not fail to be treated

1 as described in paragraph (1)(A) by reason of
2 payments being made on a per diem or other
3 periodic basis without regard to the expenses
4 incurred during the period to which the pay-
5 ments relate.

6 “(B) REFUNDS OF PREMIUMS.—Para-
7 graph (1)(D) shall not apply to any refund of
8 premiums on surrender, cancellation of the con-
9 tract, or death of the policyholder.

10 “(3) TREATMENT OF COVERAGE PROVIDED AS
11 PART OF A LIFE INSURANCE CONTRACT.—Except as
12 provided in regulations, in the case of coverage of
13 qualified long-term care services provided as part of
14 a life insurance contract—

15 “(A) APPLICATION OF GENERAL REQUIRE-
16 MENTS.—The requirements of this section shall
17 apply as if the portion of the contract providing
18 such coverage was a separate contract.

19 “(B) PREMIUMS AND CHARGES FOR
20 QUALIFIED LONG-TERM CARE COVERAGE.—Pre-
21 miums for coverage of qualified long-term care
22 services and charges against the life insurance
23 contract’s cash surrender value (within the
24 meaning of section 7702(f)(2)(A)) for such cov-

1 erage shall be treated as premiums for the
2 qualified long-term care insurance contract.

3 “(C) APPLICATION OF SECTION 7702.—
4 Subsection (c)(2) of section 7702 (relating to
5 the guideline premium limitation) shall be ap-
6 plied by increasing the guideline premium limi-
7 tation with respect to the life insurance con-
8 tract, as of any date—

9 “(i) by the sum of any charges (but
10 not premiums) described in subparagraph
11 (B) made to that date under the contract,
12 less

13 “(ii) any such charges the imposition
14 of which reduces the premiums paid for
15 the contract (within the meaning of section
16 7702(f)(1)).

17 “(D) APPLICATION OF SECTION
18 72(e)(4)(B).—Subsection (e)(4)(B) of section 72
19 (relating to certain amounts retained by the in-
20 surer) shall be applied as including charges de-
21 scribed in subparagraph (B).

22 “(E) APPLICANT.—No deduction shall be
23 allowed under subsection (a) of section 213 for
24 premiums and charges described in subpara-
25 graph (B).

1 For purposes of this paragraph, the term ‘portion’ means
2 only the terms and benefits under a life insurance contract
3 (whether provided by a rider or addendum on, or other
4 provision of, such contract) that are in addition to the
5 terms and benefits under the contract without regard to
6 the coverage of qualified long-term care services and bene-
7 fits incidental to such coverage.

8 “(c) QUALIFIED LONG-TERM CARE SERVICES.—For
9 purposes of this section—

10 “(1) IN GENERAL.—The term ‘qualified long-
11 term care services’ means necessary diagnostic, pre-
12 ventive, therapeutic, and rehabilitative services, and
13 maintenance or personal care services, which—

14 “(A) are required by an ill individual in a
15 qualified facility, and

16 “(B) are provided pursuant to a plan of
17 care prescribed by a licensed health care practi-
18 tioner, or

19 “(C) are required by law or regulation.

20 “(2) CHRONICALLY ILL INDIVIDUAL.—

21 “(A) IN GENERAL.—The term ‘chronically
22 ill individual’ means any individual who has
23 been certified by a licensed health care practi-
24 tioner as—

1 “(i)(I) being unable to perform (with-
2 out substantial assistance from another in-
3 dividual) at least two activities of daily liv-
4 ing (as defined in subparagraph (B)), due
5 to a loss of functional capacity, or

6 “(II) having a level of disability simi-
7 lar (as determined by the Secretary in con-
8 sultation with the Secretary of Health and
9 Human Services) to the level of disability
10 described in subclause (I), or

11 “(ii) having a similar level of disabil-
12 ity due to cognitive impairment.

13 “(B) ACTIVITIES OF DAILY LIVING.—For
14 purposes of subparagraph (A), each of the fol-
15 lowing is an activity of daily living:

16 “(i) BATHING.—The overall complex
17 behavior of getting water and cleansing the
18 whole body, including on the water for a
19 bath, shower, or sponge bath, getting to,
20 in, and out of a tub or shower, and wash-
21 ing and drying oneself.

22 “(ii) DRESSING.—The overall complex
23 behavior of getting clothes from closets
24 and drawers and then getting dressed.

1 “(iii) TOILETING.—The act of going
2 to the toilet room for bowel and bladder
3 function, transferring on and off the toilet,
4 cleaning after elimination, and arranging
5 clothes.

6 “(iv) TRANSFER.—The process of get-
7 ting in and out of bed or in and out of a
8 chair or wheelchair.

9 “(v) EATING.—The process of getting
10 food from a plate or its equivalent into the
11 mouth.

12 “(vi) CONTINENCE.—The ability to
13 voluntarily control bowel and bladder func-
14 tion and to maintain a reasonable level of
15 personal hygiene.

16 “(vii) STATE REQUIRED.—Any other
17 activity of daily living as required by state
18 law or regulation which is not preempted
19 by federal law or regulation.

20 “(C) NUMBER OF ACTIVITIES OF DAILY
21 LIVING.—A qualified long-term care insurance
22 contract may utilize fewer than the number of
23 activities of daily living in paragraph (B).

24 “(D) DETERMINATION OF ADDITIONAL AC-
25 TIVITIES OF DAILY LIVING.—For purposes of

1 subparagraph (A), the Secretary, in consulta-
2 tion with the Secretary of Health and Human
3 Services, may determine by regulation that ad-
4 ditional activities constitute activities of daily
5 living. If the Secretary identifies additional ac-
6 tivities of daily living, the Secretary may also
7 increase the required number of activities of
8 daily living that an individual must be unable to
9 perform to satisfy the definition of ‘chronically
10 ill individual’ when a contract utilizes activities
11 of daily living other than those specified in sub-
12 paragraph (B). Regardless of regulations issued
13 by the Secretary, long-term care contracts shall
14 not fail to meet the requirements of this para-
15 graph if such contracts utilize the activities of
16 daily living specified in subparagraph (B).

17 “(3) QUALIFIED FACILITY.—The term ‘quali-
18 fied facility’ means—

19 “(A) a nursing, rehabilitative, hospice serv-
20 ice, or adult day care facility (including a hos-
21 pital, retirement home, nursing home, skilled
22 nursing facility, intermediate care facility, or
23 similar institution)—

24 “(i) which is licensed under State law,
25 or

1 “(ii) which is a certified facility for
2 purposes of title XVIII or XIX of the So-
3 cial Security Act, or

4 “(B) an individual’s home or other facility
5 under a plan of treatment developed by a li-
6 censed health care practitioner.

7 “(4) MAINTENANCE OF PERSONAL CARE SERV-
8 ICES.—The term ‘maintenance or personal care serv-
9 ices’ means any care the primary purpose of which
10 is to provide needed assistance with any of the ac-
11 tivities of daily living described in paragraph (2)(B).
12 Such term may include such services as adult day
13 care, homemaker and chore services, hospice serv-
14 ices, respite care, and services required by law or
15 regulation.

16 “(5) LICENSED HEALTH CARE PRACTI-
17 TIONER.—The term ‘licensed health care practi-
18 tioner’ means any physician (as defined in section
19 1861(r) of the Social Security Act) and any reg-
20 istered professional nurse, licensed social worker, or
21 other individual who meets such requirements as
22 may be prescribed by the Secretary.

23 “(d) SPECIAL RULES.—

24 “(1) CONTINUATION RULES NOT TO APPLY.—
25 The health care continuation rules contained in sec-

1 tion 4980B (and contained in part 6 of subtitle B
2 of title I of the Employee Retirement Income Secu-
3 rity Act of 1974 and in title II of the Public Health
4 Service Act) shall not apply to—

5 “(A) qualified long-term care insurance
6 contracts, or

7 “(B) plans described in subsection (a)(2).

8 “(2) EMPLOYER PLANS NOT TREATED AS DE-
9 FERRED COMPENSATION PLANS.—For purposes of
10 this title, a plan of an employer providing coverage
11 of qualified long-term care services shall not be
12 treated as a plan which provides for deferred com-
13 pensation by reason of providing such coverage.

14 “(3) CONTRACTS COVERING PARENTS AND
15 GRANDPARENTS.—For purposes of this title, if a
16 qualified long-term care insurance contract pur-
17 chased by or provided to a taxpayer provides cov-
18 erage with respect to one or more of the taxpayer’s
19 parents or grandparents (or, in the case of a joint
20 return, of either spouse), such coverage and all pay-
21 ments made pursuant to such coverage shall be
22 treated in the same manner as if the parents or
23 grandparents were dependents (as defined in section
24 152) of the taxpayer. For purposes of this para-
25 graph, the term ‘parent’ includes any stepmother or

1 stepfather, the term ‘grandparent’ includes any
2 stepgrandfather or stepgrandmother, and any rela-
3 tionship that exists by virtue of a legal adoption
4 shall be recognized to the same extent as relation-
5 ships by blood.

6 “(4) WELFARE BENEFIT RULES NOT TO
7 APPLY.—For purposes of subpart D of part I of
8 subchapter D of chapter 1 (relating to treatment of
9 welfare benefit funds), qualified long-term care serv-
10 ices shall not be treated as a welfare benefit or a
11 medical benefit.

12 “(5) DEDUCTIBILITY.—For purposes of this
13 title, no payment of a premium for a long-term care
14 insurance contract shall fail to be deductible in
15 whole or in part merely because the contract pro-
16 vides for level annual payments.

17 “(e) REGULATIONS.—The Secretary shall prescribe
18 such regulations as may be necessary to carry out the re-
19 quirements of this section, including regulations to prevent
20 the avoidance of this section by providing qualified long-
21 term care services under a life insurance contract.”.

22 (b) The table of sections for chapter 79 of the Inter-
23 nal Revenue Code of 1986 is amended by inserting after
24 the item relating to section 7702A the following new item:

“Sec. 7702B. Treatment of long-term care insurance or plans.”.

1 **SEC. 303. QUALIFIED LONG-TERM SERVICES TREATED AS**
2 **MEDICAL CARE.**

3 (a) Paragraph (1) of section 213(d) of the Internal
4 Revenue Code of 1986 (defining medical care) is amended
5 by striking “or” at the end of subparagraph (B), by redesi-
6 gnating subparagraph (C) as subparagraph (D), and by
7 inserting after subparagraph (B) the following new sub-
8 paragraph:

9 “(C) for qualified long-term care services
10 (as defined in section 7702B(c)), or”.

11 (b)(1) Subparagraph (D) of section 213(d)(1) of the
12 Internal Revenue Code of 1986 (as redesigned by sub-
13 section (a)) is amended by striking “subparagraphs (A)
14 and (B)” and inserting “subparagraphs (A), (B), and
15 (C)”.

16 (2) Paragraph (6) of section 213(d) of such Code is
17 amended—

18 (A) by striking “subparagraphs (A) and (B)”
19 and inserting “subparagraphs (A), (B), and (C)”,
20 and

21 (B) by striking “paragraph (1)(C)” in subpara-
22 graph (A) and inserting “paragraph (1)(D)”.

23 (3) Paragraph (7) of section 213(d) of such Code is
24 amended by striking “subparagraphs (A) and (B)” and
25 inserting “subparagraphs (A), (B), and (C)”.

1 **SEC. 304. QUALIFIED LONG-TERM CARE INSURANCE CON-**
2 **TRACTS PERMITTED TO BE OFFERED IN CAF-**
3 **ETERIA PLANS.**

4 Paragraph (2) of section 125(d) of the Internal Reve-
5 nue Code of 1986 (relating to the exclusion of deferred
6 compensation) is amended by adding at the end thereof
7 the following new subparagraph:

8 “(D) EXCEPTION FOR LONG-TERM CARE
9 INSURANCE CONTRACTS.—For purposes of sub-
10 paragraph (A), a plan shall not be treated as
11 providing deferred compensation by reason of
12 providing any long-term care insurance contract
13 (as defined in section 7702B(b)) if—

14 “(i) the employee may elect to con-
15 tinue the insurance upon cessation of par-
16 ticipation in the plan, and

17 “(ii) the amount paid or incurred dur-
18 ing any taxable year for such insurance
19 does not exceed the premium which would
20 have been payable for such year under a
21 level premium structure.”.

22 **SEC. 305. INCLUSION IN INCOME OF EXCESSIVE LONG-**
23 **TERM CARE BENEFITS.**

24 (a) Part II of subchapter B of chapter 1 of the Inter-
25 nal Revenue Code of 1986 (relating to items specifically

1 included in gross income) is amended by adding at the
2 end the following new section:

3 **“SEC. 91. EXCESSIVE LONG-TERM CARE BENEFITS.**

4 “(a) GENERAL RULE.—Gross income for the taxable
5 year of any individual includes excessive long-term care
6 benefits received by or for the benefit of such individual
7 during the taxable year.

8 “(b) EXCESSIVE LONG-TERM CARE BENEFITS.—

9 “(1) IN GENERAL.—For purposes of this sec-
10 tion, the term ‘excessive long-term care benefits’
11 means the excess (if any) of—

12 “(A) the aggregate amount from all poli-
13 cies which is not includible in the gross income
14 of the individual for the taxable year by reason
15 of the amendments made by the Private Long-
16 Term Care Insurance Incentive Amendments of
17 1994 (determined without regard to this sec-
18 tion), over

19 “(B) the aggregate of \$250 for each day
20 during the taxable year that such individual—

21 “(i) was a chronically ill individual (as
22 defined in section 7702B(c)(2)), and

23 “(ii) was confined to a qualified facil-
24 ity (as defined in section 7702B(c)(3)).

1 “(2) INFLATION ADJUSTMENT.—In the case of
2 any taxable year beginning after 1995, the \$250 in
3 paragraph (1)(B) shall be equal to the sum of—

4 “(A) the amount in effect under paragraph
5 (1)(B) for the preceding calendar year (after
6 application of this subparagraph), plus

7 “(B) the product of the amount referred to
8 in subclause (A) multiplied by the cost-of-living
9 adjustment for the calendar year of the amount
10 under subclause (A).

11 “(3) COST-OF-LIVING ADJUSTMENT.—For pur-
12 poses of paragraph (2), the cost-of-living adjustment
13 for any calendar year is the percentage (if any) by
14 which the cost index under paragraph (4) for the
15 preceding calendar year exceeds such index for the
16 second preceding calendar year.

17 “(4) COST INDEX.—The Secretary, in consulta-
18 tion with the Secretary of Health and Human Serv-
19 ices, shall before January 1, 1996, establish a cost
20 index to measure increases in the cost of nursing
21 home and similar facilities. The Secretary may from
22 time to time revise such index to the extent nec-
23 essary to accurately measure increase or decreases
24 in such costs.

1 any qualified long-term care insurance con-
2 tract (as defined in section 7702B(c))—

3 “(I) the reserve method pre-
4 scribed by the National Association of
5 Insurance Commissioners which cov-
6 ers such contract (as of the date of is-
7 suance), or

8 “(II) if no reserve method has
9 been prescribed by the National Asso-
10 ciation of Insurance Commissioners
11 which covers such contract, a 1-year
12 full preliminary term method.”.

13 (b)(1) Clause (iii) of section 807(d)(3)(A) of the In-
14 ternal Revenue Code of 1986 is amended by striking
15 “noncancellable accident and health insurance contract,”
16 and inserting “noncancellable accident and health insur-
17 ance contract (other than qualified long-term care insur-
18 ance contracts (as defined in section 7702B(c)),”.

19 (2) Clause (v) of section 807(d)(3)(A) of such Code
20 (as redesignated by subsection (a)) is amended by striking
21 “or (iii)” and inserting “(iii), or (iv)”.

22 **SEC. 307. EFFECTIVE DATE.**

23 (a) Except as provided in subsection (b), the amend-
24 ments made by this title shall apply to policies issued in

1 taxable years beginning after the date of the enactment
2 of this Act.

3 (b) Policies issued prior to or during the taxable year
4 in which this Act is enacted that met the requirements
5 of the National Association of Insurance Commissioners'
6 Model Long-Term Care Act and Regulation when the pol-
7 icy was issued shall be considered qualified long-term care
8 insurance and the services provided under such policies
9 shall be considered qualified long-term care services.

10 **TITLE IV—LONG-TERM CARE** 11 **INSURANCE STANDARDS**

12 **SEC. 400. SHORT TITLE.**

13 This title may be cited as the “Long-Term Care
14 Insurance Standards Amendments of 1994”.

15 **SEC. 401. NATIONAL LONG-TERM CARE INSURANCE ADVI-** 16 **SORY COUNCIL.**

17 (a) Congress shall appoint an advisory board to be
18 known as the National Long-Term Care Insurance Advi-
19 sory Council (hereinafter referred to as the “Advisory
20 Council”).

21 (b) The Advisory Council shall consist of 5 members,
22 each of whom has substantial expertise in matters relating
23 to the provision and regulation of long-term care insurance
24 or long-term care financing and delivery systems.

25 (c) The Advisory Council shall—

1 (1) provide advice, recommendations, and as-
2 sistance to Congress on matters relating to long-
3 term care insurance as specified in this section and
4 as otherwise required by the Secretary;

5 (2) collect, analyze, and disseminate informa-
6 tion relating to long-term care insurance in order to
7 increase the understanding of insurers, providers,
8 consumers, and regulatory bodies of the issues relat-
9 ing to, and to facilitate improvements in, such insur-
10 ance;

11 (3) develop for congressional consideration pro-
12 posed models, standards, requirements, and proce-
13 dures relating to long-term care insurance, as appro-
14 priate; and

15 (4) monitor the development of the long-term
16 care insurance market and advise Congress concern-
17 ing the need for statutory changes.

18 (d) In order to carry out its responsibilities under this
19 section, the Advisory Council is authorized to—

20 (1) consult individuals and public and private
21 entities with experience and expertise in matters re-
22 lating to long-term care insurance;

23 (2) conduct meetings and hold hearings;

24 (3) conduct research (either directly or under
25 grant or contract);

1 (4) collect, analyze, publish, and disseminate
2 data and information (either directly or under grant
3 or contract); and

4 (5) develop model formats and procedures for
5 insurance products; and develop proposed standards,
6 rules and procedures for regulatory programs, as
7 appropriate.

8 (e) There are authorized to be appropriated, for ac-
9 tivities of the Advisory Council, \$1,500,000 for fiscal year
10 1995, and each subsequent year.

11 **SEC. 402. POLICY REQUIREMENTS.**

12 (a) Section 7702B of the Internal Revenue Code of
13 1986 (as added by section 302) is amended by inserting
14 after subsection (e) the following new subsection:

15 “(f) CONSUMER PROTECTION PROVISIONS.—

16 “(1) IN GENERAL.—The requirements of this
17 subsection are met with respect to any contract if
18 any long-term care insurance policy issued under the
19 contract meets—

20 “(A) the requirements of the model regula-
21 tion and model Act described in paragraph (2),

22 “(B) the disclosure requirement of para-
23 graph (3),

24 “(C) the requirements relating to
25 nonforfeitability under paragraph (4), and

1 “(D) the requirements relating to rate sta-
2 bilization under the paragraph (5),

3 “(2) REQUIREMENTS OF MODEL REGULATION
4 AND ACT.—

5 “(A) IN GENERAL.—The requirements of
6 this paragraph are met with respect to any pol-
7 icy if such policy meets—

8 “(i) MODEL REGULATION.—The fol-
9 lowing requirements of the model regula-
10 tion:

11 “(I) Section 7A (relating to guar-
12 anteed renewal or noncancellability),
13 and the requirements of section 6B of
14 the model Act relating to such section
15 7A.

16 “(II) Section 7B (relating to pro-
17 hibitions on limitations and exclu-
18 sions).

19 “(III) Section 7C (relating to ex-
20 tension of benefits).

21 “(IV) Section 7D (relating to
22 continuation or conversion of cov-
23 erage).

1 “(V) Section 7E (relating to dis-
2 continuance and replacement of poli-
3 cies).

4 “(VI) Section 8 (relating to unin-
5 tentional lapse).

6 “(VII) Section 9 (relating to dis-
7 closure), other than Section 9F there-
8 of.

9 “(VIII) Section 10 (relating to
10 prohibitions against post-claims un-
11 derwriting).

12 “(IX) Section 11 (relating to
13 minimum standards).

14 “(X) Section 12 (relating to re-
15 quirement to offer inflation protec-
16 tion), except that any requirement for
17 a signature on a rejection of inflation
18 protection shall permit the signature
19 to be on an application or on a sepa-
20 rate form.

21 “(XI) Section 23 (relating to pro-
22 hibition against preexisting conditions
23 and probationary periods in replace-
24 ment policies or certificates).

1 “(ii) MODEL ACT.—The following re-
2 quirements of the model Act:

3 “(I) Section 6C (relating to pre-
4 existing conditions).

5 “(II) Section 6D (relating to
6 prior hospitalization).

7 “(B) DEFINITIONS.—For purposes of this
8 paragraph—

9 “(i) MODEL PROVISIONS.—The terms
10 ‘model regulation’ and ‘model Act’ mean
11 the long-term care insurance model regula-
12 tion, and the long-term care insurance
13 model Act, respectively, promulgated by
14 the National Association of Insurance
15 Commissioners (as adopted in January of
16 1993).

17 “(ii) COORDINATION.—Any provision
18 of the model regulation or model Act listed
19 under clause (i) or (ii) of subparagraph
20 (A) shall be treated as including any other
21 provision of such regulation or Act nec-
22 essary to implement the provision.

23 “(3) TAX DISCLOSURE REQUIREMENT.—The re-
24 quirement of this paragraph is met with respect to

1 any policy if such policy meets the requirements of
2 section 4980D(d)(1).

3 “(4) NONFORFEITURE REQUIREMENTS.—

4 “(A) IN GENERAL.—The requirements of
5 this paragraph are met with respect to any level
6 premium long-term care insurance policy if the
7 issuer of such policy offers to the policyholder,
8 including any group policyholder, a
9 nonforfeiture provision.

10 “(B) REQUIREMENTS OF PROVISION.—The
11 nonforfeiture provision required under subpara-
12 graph (A) shall meet the following require-
13 ments:

14 “(i) The nonforfeiture provision shall
15 be appropriate captioned.

16 “(ii) The nonforfeiture provision shall
17 provide for a benefit available in the event
18 of a default in the payment of any pre-
19 miums and the amount of the benefit may
20 be adjusted subsequent to being initially
21 granted only as necessary to reflect
22 changes in claims, persistency, and interest
23 as reflected in changes in rates for pre-
24 mium paying policies approved by the Sec-
25 retary for the same policy form.

1 “(iii) The nonforfeiture provision shall
2 provide for a benefit based on an equitable
3 schedule where benefits returned are equal
4 to the asset share remaining in the policy
5 and which assures that persisting policy-
6 holders are not required to subsidize the
7 cost of insurance premiums for policy-
8 holders who terminate coverage. The cri-
9 teria for determining the actuarial value of
10 this benefit shall be developed by the Na-
11 tional Long-Term Care Insurance Advisory
12 Committee in consultation with the Amer-
13 ican Society of Actuaries and the National
14 Association of Insurance Commissioners
15 and shall be approved by Congress.

16 “(5) RATE STABILIZATION.—

17 “(A) IN GENERAL.—The requirements of
18 this paragraph are met with respect to any
19 long-term care insurance policy, including any
20 group master policy, if—

21 “(i) such policy contains the minimum
22 rate guarantees specified in subparagraph
23 (B), and

1 “(ii) the issuer of such policy meets
2 the requirements specified in subparagraph
3 (C).

4 “(B) MINIMUM RATE GUARANTEES.—The
5 minimum rate guarantees specified in this sub-
6 paragraph are as follows:

7 “(i) Rates under the policy shall be
8 guaranteed for a period of at least 3 years
9 from the date of issue of the policy.

10 “(ii) After the expiration of the 3-year
11 period required under clause (i), any rate
12 increase shall be guaranteed for a period of
13 at least 2 years from the effective date of
14 such rate increase.

15 “(iii) In the case of any individual age
16 75 or older who has maintained coverage
17 under a long-term care insurance policy for
18 10 years, rate increase under such policy
19 shall not exceed 10 percent in any 12-
20 month period.

21 “(C) INCREASES IN PREMIUMS.—The re-
22 quirements specified in this subparagraph are
23 as follows:

24 “(i) IN GENERAL.—If an issuer of any
25 long-term care insurance policy, including

1 any group master policy, plans to increase
2 the premium rates for a policy, such issuer
3 shall, at least 90 days before the effective
4 date of the rate increase, offer to each in-
5 dividual policyholder under such policy the
6 option to remain insured under the policy
7 at a reduced level of benefits which main-
8 tains the premium rate at the rate in effect
9 on the day before the effective date of the
10 rate increase.

11 “(ii) INCREASE OF MORE THAN 50
12 PERCENT.—

13 “(I) IN GENERAL.—If an issuer
14 of any long-term care insurance pol-
15 icy, including any group master pol-
16 icy, increases premium rates for a pol-
17 icy by more than 50 percent in any 3-
18 year period—

19 “(aa) in the case of a group
20 master long-term care insurance
21 policy, the issuer shall dis-
22 continue issuing all group master
23 long-term care insurance policies
24 in any State in which the issuer
25 issues such policy for a period of

1 2 years from the effective date of
2 such premium increase; and

3 “(bb) in the case of an indi-
4 vidual long-term care insurance
5 policy, the issuer shall dis-
6 continue issuing all individual
7 long-term care policies in any
8 State in which the issuer issues
9 such policy for a period of 2
10 years from the effective date of
11 such premium increase.

12 “(II) APPLICABILITY.—Subclause
13 (I) shall apply to any issuer of long-
14 term care insurance policies or any
15 other person that purchases or other-
16 wise acquires any long-term care in-
17 surance policies from another issuer
18 or person.

19 “(D) MODIFICATIONS OR WAIVERS OF RE-
20 QUIREMENTS.—The Secretary may modify or
21 waive any of the requirements under this para-
22 graph if—

23 “(i) such requirements will adversely
24 affect an issuer’s solvency;

1 “(ii) such modification or waiver is re-
2 quired for the issuer to meet other State or
3 Federal requirements;

4 “(iii) medical developments, new dis-
5 abling diseases, changes in long-term care
6 delivery, or a new method of financing
7 long-term care will result in changes to
8 mortality and morbidity patterns or as-
9 sumptions;

10 “(iv) judicial interpretations of a pol-
11 icy’s benefit features results in unintended
12 claim liabilities; or

13 “(v) in the case of a purchase or other
14 acquisition of long-term care insurance
15 policies of an issuer or other person, the
16 continued sale of other long-term care in-
17 surance policies by the purchasing issuer
18 or person is in the best interest of individ-
19 ual consumers.

20 “(6) LONG-TERM CARE INSURANCE POLICY DE-
21 FINED.—For purposes of this subsection, the term
22 ‘long-term care insurance policy’ has the meaning
23 given such term by section 4980C(e).”.

1 **SEC. 403. ADDITIONAL REQUIREMENTS FOR ISSUERS OF**
2 **LONG-TERM CARE INSURANCE POLICIES.**

3 (a) Chapter 43 of the Internal Revenue Code of
4 1986 is amended by adding at the end the following
5 new section:

6 **“SEC. 4980C. FAILURE TO MEET REQUIREMENTS FOR LONG-**
7 **TERM CARE INSURANCE POLICIES.**

8 “(a) GENERAL RULE.—There is hereby imposed on
9 any person failing to meet the requirements of subsection
10 (c) or (d) a tax in the amount determined under sub-
11 section (b).

12 “(b) AMOUNT OF TAX.—

13 “(1) IN GENERAL.—For purposes of subsection
14 (a), the amount of the tax shall not exceed the
15 greater of—

16 “(A) 3 times the amount of any commis-
17 sions paid for each policy involved in the viola-
18 tion, or

19 “(B) \$10,000.

20 “(2) WAIVER.—In the case of a failure which is
21 due to reasonable cause and not to willful neglect,
22 the Secretary may waive part or all of the tax im-
23 posed by subsection (a) to the extent that payment
24 of the tax would be excessive relative to the failure
25 involved.

1 “(c) ADDITIONAL RESPONSIBILITIES.—The require-
2 ments of this subsection are as follows:

3 “(1) REQUIREMENTS OF MODEL PROVISIONS.—

4 “(A) MODEL REGULATION.—The following
5 requirements of the model regulation must be
6 met:

7 “(i) Section 13 (relating to application
8 forms and replacement coverage).

9 “(ii) Section 14 (relating to reporting
10 requirements), except that the issuer shall
11 also report at least annually the number of
12 claims denied during the reporting period
13 for each class of business (expended as a
14 percentage of claims denied), other than
15 claims denied for failure to meet the
16 waiving period or because of any applicable
17 pre-existing condition.

18 “(iii) Section 20 (relating to filing re-
19 quirements for marketing).

20 “(iv) Section 21 (relating to standards
21 for marketing), including inaccurate com-
22 pletion of medical histories, other than sec-
23 tion 21C(1), 21(C)(3) and 21C(6) thereof,
24 except that—

1 “(I) in addition to such require-
2 ments, no person shall in selling or of-
3 fering to sell a long-term care insur-
4 ance policy, misrepresent a material
5 fact;

6 “(II) no such requirements shall
7 include a requirement to inquire or
8 identify whether a prospective appli-
9 cant or enrollee for long-term care in-
10 surance has accident and sickness in-
11 surance; and

12 “(III) the association shall dis-
13 close in any long-term care insurance
14 solicitation the amount of compensa-
15 tion that the association receives from
16 endorsement or sale of the policy or
17 certificate to its members, expressed
18 as a percentage of annual premium
19 generated by such policies.

20 “(v) Section 22 (relating to appro-
21 priateness of recommended purchase).

22 “(vi) Section 24 (relating to standard
23 format outline of coverage).

24 “(vii) Section 25 (relating to require-
25 ment to deliver shopper’s guide).

1 “(B) MODEL ACT.—The following require-
2 ments of the model Act must be met:

3 “(i) Section 6F (relating to right to
4 return), except that such section shall also
5 apply to denials of applications and any re-
6 fund shall be made within 30 days of the
7 return or denial.

8 “(ii) Section 6G (relating to outline of
9 coverage).

10 “(iii) Section 6H (relating to require-
11 ments for certificates under group plans).

12 “(iv) Section 6I (relating to policy
13 summary).

14 “(v) Section 6J (relating to monthly
15 reports on accelerated death benefits).

16 “(vi) Section 7 (relating to incontest-
17 ability period).

18 “(C) DEFINITIONS.—For purposes of this
19 paragraph, the terms ‘model regulation’ and
20 ‘model Act’ have the meanings given such terms
21 by section 7702B(f)(2)(B).

22 “(2) DELIVERY OF POLICY.—If an application
23 for a long-term care insurance policy (or for a cer-
24 tificate under a group long-term care insurance pol-
25 icy) is approved, the issuer shall deliver to the appli-

1 cant (or policyholder or certificate-holder) the policy
2 (or certificate) of insurance not later than 30 days
3 after the date of the approval.

4 “(3) INFORMATION ON DENIALS OF CLAIMS.—
5 If a claim under a long-term care insurance policy
6 is denied, the issuer shall, within 60 days of the date
7 of a written request by the policyholder or certifi-
8 cate-holder (or representative)—

9 “(A) provide a written explanation of the
10 reasons for the denial, and

11 “(B) make available all information di-
12 rectly relating to such denial except in cases
13 where such issuer would be prohibited from pro-
14 viding information regarding claims denial
15 under confidentiality statutes or other state or
16 Federal laws.

17 “(d) DISCLOSURE.—The requirements of this sub-
18 section are met if either of the following statements,
19 whichever is applicable, is prominently displayed on the
20 front page of any long-term care insurance policy and in
21 the outline of coverage required under subsection
22 (c)(1)(B)(ii):

23 “(1) A statement that: ‘This policy is intended
24 to be a qualified long-term care insurance contract

1 under section 7702B(b) of the Internal Revenue
2 Code of 1986.’.

3 “(2) A statement that: ‘This policy is not in-
4 tended to be a qualified long-term care insurance
5 contract under section 7702B(b) of the Internal
6 Revenue Code of 1986.’.

7 “(e) LONG-TERM CARE INSURANCE POLICY DE-
8 FINED.—For purposes of this section, the term ‘long-term
9 care insurance policy’ means any insurance policy or rider
10 advertised, marketed, offered or designed to provide cov-
11 erage for not less than 12 consecutive months for each
12 covered person on an expense incurred, indemnity, prepaid
13 or other basis; for one or more necessary diagnostic, pre-
14 ventive, therapeutic, rehabilitative, maintenance or per-
15 sonal care services, provided in a setting other than an
16 acute care unit of a hospital. Such term includes group
17 and individual annuities and life insurance policies or rid-
18 ers which provide directly or which supplement long-term
19 care insurance. Such term also includes a policy or rider
20 which provides for payment of benefits based upon cog-
21 nitive impairment or the loss of functional capacity. Long-
22 term care insurance may be issued by insurers; fraternal
23 benefit societies; nonprofit health, hospital and medical
24 service corporations; prepaid health plans; health mainte-
25 nance organizations or any similar organization to the ex-

1 tent such organizations are otherwise authorized to issue
2 life or health insurance. Long-term care insurance shall
3 not include any insurance policy which is offered primarily
4 to provide basic medicare supplement coverage, basic hos-
5 pital expense coverage, basic medical-surgical expense cov-
6 erage, hospital confinement indemnity coverage, major
7 medical expense coverage, disability income or related
8 asset-protection coverage, accident only coverage, specified
9 disease or specified accident coverage, or limited benefit
10 health coverage. With regard to life insurance, this term
11 does not include life insurance policies which accelerate
12 the death benefit specifically for one or more of the quali-
13 fying events of terminal illness, medical conditions requir-
14 ing extraordinary medical intervention, or permanent in-
15 stitutional confinement, and which provide the option of
16 a lump-sum payment for those benefits and in which nei-
17 ther the benefits nor the eligibility for the benefits is con-
18 ditioned upon the receipt of long-term care.”.

19 (b) The table of sections for chapter 43 of the Inter-
20 nal Revenue Code of 1986 is amended by adding at the
21 end the following new item:

“Sec. 4980C. Failure to meet requirements for long-term care insurance poli-
cies.”.

22 **SEC. 404. RELATION TO STATE LAW.**

23 Insurance policies which have been deemed in compli-
24 ance with the requirements of this title and the Internal

1 Revenue Code of 1986 (as amended by this title) by the
2 State Insurance Commissioner in the State of domicile
3 shall be deemed approved for sale in any other State. No
4 State may prohibit an insurance carrier from selling out-
5 side the State of domicile long-term care insurance policies
6 which have been approved in the State of domicile.

7 **SEC. 405. UNIFORM LANGUAGE AND DEFINITIONS.**

8 (a) The Advisory Council shall develop recommenda-
9 tions for the use of uniform language and definitions in
10 long-term care insurance policies (as defined in section
11 4980C(e) of the Internal Revenue Code of 1986) for ap-
12 proval by Congress.

13 (b) Standards under subsection (a) may permit the
14 use of nonuniform language to the extent required to take
15 into account differences among States in the licensing of
16 nursing facilities and other providers of long-term care.

17 **SEC. 406. EFFECTIVE DATES.**

18 (a) The amendments made by section 402 shall apply
19 to contracts issued in taxable years beginning after the
20 date of the enactment of this Act.

21 (b) The amendments made by section 402 shall apply
22 to actions taken in taxable years beginning after the date
23 of the enactment of this Act.

1 **TITLE V—FINANCIAL**
2 **ELIGIBILITY STANDARDS**

3 **SEC. 501. REVISIONS TO FINANCIAL ELIGIBILITY PROVI-**
4 **SIONS.**

5 (a) Section 1902(a) of the Social Security Act (42
6 U.S.C. 1396a(a)) is amended—

7 (1) in paragraph (17)(C), by inserting “subject
8 to subsection (z),” before “provide”, and

9 (2) by adding at the end the following new sub-
10 section:

11 “(z)(1) For purposes of subsection (a)(17)(C), not-
12 withstanding any other provision of this title, the re-
13 sources of an individual, and the spouse of such individual,
14 which shall be used to determine financial eligibility for
15 nursing facility services under this title shall include—

16 “(A) all of the real property owned by the indi-
17 vidual, including but not limited to, the individual’s
18 primary residence;

19 “(B) all personal property of the individual, in-
20 cluding but not limited to, any automobiles owned by
21 the individual; and

22 “(C) all liquid assets held by the individual, in-
23 cluding but not limited to, the asset value of any
24 trust established by such individual.

1 “(2)(A) An individual shall not be eligible for nursing
2 facility services under this title if the total value of the
3 resources owned by the individual (individually or jointly
4 with his or her spouse, if any) exceeds the value of the
5 median price of a home in the geographic region in which
6 such individual resides.

7 “(B) For purposes of subparagraph (A), the Sec-
8 retary shall establish a valuation system for single family
9 homes in appropriate geographic regions, taking appro-
10 priate account of the variation in values between urban
11 and rural areas. The valuation system established by the
12 Secretary shall be updated annually.

13 “(C) Subparagraph (A) shall apply for a couple in
14 the same manner as such subparagraph applies for an in-
15 dividual where one member of the couple applies for nurs-
16 ing facility services under this title.

17 “(D) For purposes of determining the total value of
18 resources in paragraph (A), the value of resources held
19 jointly with the individual’s spouse shall be considered
20 available to the individual applying for medical assistance
21 as determined under section 1924(d)(2).

22 “(3) No provision under this subsection shall affect
23 the community spouse protections contained in section
24 1924.

1 “(4) The Secretary shall provide grants to States for
2 demonstration projects to investigate the coordination of
3 private long-term care insurance benefits and financial eli-
4 gibility requirements under this title. Such demonstration
5 projects shall include, but not be limited to, investigations
6 of—

7 “(A) a State policy which subtracts the
8 amounts paid by an individual for private long-term
9 care insurance from the individual’s resources which
10 are counted to determine financial eligibility; and

11 “(B) a State policy which provides purchasers
12 of private long-term care insurance with impoverish-
13 ment protections by using medicaid as reinsurance.

14 “(5) Eligibility requirements under paragraphs (1)
15 through (4) of this subsection shall not apply to services
16 provided under this title other than nursing facility serv-
17 ices.”.

18 **SEC. 502. EFFECTIVE DATE.**

19 The amendments made by this title shall be effective
20 January 1, 1995.

1 **TITLE VI—ESTABLISHMENT OF**
2 **PROGRAM FOR HOME AND**
3 **COMMUNITY-BASED SERV-**
4 **ICES FOR CERTAIN INDIVID-**
5 **UALS WITH DISABILITIES**

6 **SEC. 600. SHORT TITLE.**

7 This title may be cited as the “Home and Commu-
8 nity-Based Services for Individuals with Disabilities Pro-
9 gram Amendments of 1994”.

10 **SEC. 601. ESTABLISHMENT OF PROGRAM.**

11 (a) ESTABLISHMENT OF PROGRAM.—Title XIX of
12 the Social Security Act (42 U.S.C. 1396 et seq.) is amend-
13 ed by redesignating section 1931 as section 1932 and by
14 inserting after section 1931 the following new section:

15 “HOME AND COMMUNITY-BASED SERVICES FOR
16 INDIVIDUALS WITH DISABILITIES.

17 “SEC. 1932. (a) IN GENERAL.—There is hereby es-
18 tablished a program under which States will be required
19 to provide for home and community-based services as de-
20 scribed in this section on behalf of individuals with disabil-
21 ities who meet the requirements described in this section.
22 This program is established notwithstanding any other
23 provisions of this title, and such services must be provided
24 to all such individuals by a State that has an approved
25 State plan under this title. The State shall not have re-

1 sponsibility to cover such services under this title to the
2 extent that such services are provided to an individual
3 under any other public programs. All provisions of this
4 title shall be applicable to the program established under
5 this section except as are inconsistent with this section.

6 “(b) ELIGIBILITY.—

7 “(1) INDIVIDUALS WITH DISABILITIES DE-
8 FINED.—In this section, the term ‘individual with
9 disabilities’ means any individual who falls within
10 one or both of the following 2 categories of individ-
11 uals:

12 “(A) INDIVIDUALS REQUIRING HELP WITH
13 ACTIVITIES OF DAILY LIVING.—An individual of
14 any age who—

15 “(i) requires hands-on or standby as-
16 sistance, supervision, or cueing (as defined
17 in regulations) to perform 3 or more activi-
18 ties of daily living (as defined in paragraph
19 (2)), and

20 “(ii) is expected to require such as-
21 sistance, supervision, or cueing over a pe-
22 riod of at least 100 days.

23 “(B) INDIVIDUALS WITH MODERATE COG-
24 NITIVE OR MENTAL IMPAIRMENT.—An individ-
25 ual of any age—

1 “(i) whose score, on a standard men-
2 tal status protocol (or protocols) appro-
3 priate for measuring the individual’s par-
4 ticular condition specified by the Secretary,
5 indicates either moderate cognitive impair-
6 ment or moderate mental impairment, or
7 both;

8 “(ii) who displays symptoms of one or
9 more serious behavioral problems (that is
10 on a list of such problems specified by the
11 Secretary) which create a need for super-
12 vision to prevent harm to self or others;
13 and

14 “(iii) who is expected to meet the con-
15 ditions of clauses (i) or (ii) over a period
16 of at least 100 days.

17 “(2) ACTIVITY OF DAILY LIVING DE-
18 FINED.—In this section, the term ‘activity of
19 daily living’ means any of the following: eating,
20 toileting (dressing and bathing), transferring,
21 and mobility.

22 “(c) SCREENING.—

23 “(1) INITIAL SCREENING.—The State shall pro-
24 vide for an initial screening of all individuals who
25 appear to have some reasonable likelihood of being

1 an individual with disabilities. Such a screening may
2 be conducted by a qualified case manager, or by any
3 other person or entity designated by the State under
4 criteria specified by the Secretary. Such assessment
5 shall be conducted using a uniform protocol specified
6 by the Secretary. A State may specify the collection
7 of additional information, or an alternative protocol, if
8 approved in advance by the Secretary. Such assess-
9 ment shall include, at a minimum an assessment of
10 the individual's—

11 “(A) ability or inability to perform any ac-
12 tivities of daily living;

13 “(B) health status;

14 “(C) mental status;

15 “(D) current living arrangement; and

16 “(E) use of formal and informal long-term
17 care support systems.

18 “(2) PERIODIC REASSESSMENT.—For any indi-
19 vidual who receives services under this program, the
20 State shall arrange for a reassessment of the indi-
21 vidual's need for services under this section after a
22 significant change in an individual's condition that
23 may affect the individual's need for such services,
24 within 6 months of the most recent assessment, or
25 for such longer period in such cases as a significant

1 change in an individual's condition that may affect
2 such determination is unlikely.

3 “(d) CARE PLAN DEVELOPMENT.—

4 “(1) IN GENERAL.—The State shall assign a
5 qualified case manager to any individual who quali-
6 fies for coverage under this section. The qualified
7 case manager shall arrange for the development of,
8 or develop, an individualized written plan of care
9 based upon the comprehensive assessment. The care
10 plan shall be developed under any criteria that may
11 be specified by the State based upon any criteria
12 that the Secretary may specify. At a minimum, such
13 plan shall identify—

14 “(A) the long-term problems and needs of
15 the individual;

16 “(B) the mix of formal and informal serv-
17 ices and support systems that are available to
18 meet the long-term care and service needs of
19 the individual;

20 “(C) goals for the individual which shall be
21 measurable to the extent practicable;

22 “(D) the appropriate services necessary to
23 meet such needs; and

24 “(E) the manner in which covered services
25 will be provided.

1 “(2) PROVISION OF SERVICES.—

2 “(A) COVERED SERVICES.—The qualified
3 case manager, in consultation with the individ-
4 ual, the individual’s family and the individual’s
5 primary medical care provider, shall arrange
6 for, or provide, the appropriate covered services
7 in a cost-effective manner, consistent with ob-
8 taining quality care. The qualified case man-
9 ager also shall assist in making the necessary
10 arrangements for the delivery of such services
11 and the implementation of the care plan.

12 “(B) NON-COVERED SERVICES.—The State
13 may require the qualified case manager to as-
14 sist the individual in obtaining non-covered
15 services, at the individual’s own expense, or
16 through other programs that may be available.
17 Nothing in this section shall be construed to
18 make the State responsible for payment under
19 this section for any services that are not cov-
20 ered services, as defined in subsection (f)(1), or
21 from prohibiting the individual, or other indi-
22 viduals, from paying for non-covered services or
23 services in excess of the amount or type ap-
24 proved by the case manager.

1 “(C) INDIVIDUAL CHOICE.—The accept-
2 ance of benefits under this provision is a vol-
3 untary choice of the individual or his or her
4 representative. Nothing in this section shall be
5 construed to require an individual to accept the
6 services available under this section, or to ac-
7 cept benefits under this section instead of en-
8 tering a nursing facility, skilled nursing facility,
9 or intermediate care facility for the mentally re-
10 tarded. An individual shall not be denied other
11 covered services under this section solely be-
12 cause he or she refuses to accept one such cov-
13 ered service, unless the failure to accept that
14 one covered service would vitiate the effective-
15 ness of the other covered services, and no cost-
16 effective alternative acceptable to the individual
17 is reasonably available. To the extent possible,
18 the case manager shall follow the choice of an
19 individual with disabilities regarding which cov-
20 ered services to receive and the providers who
21 will provide such services.

22 “(3) COORDINATION.—The plan shall specify
23 how the plan will integrate services provided under
24 this section with services provided under titles V and
25 XX of this Act and the Housing and Urban Devel-

1 opment Act, programs under the Older Americans
2 Act of 1965, and any other Federal or State pro-
3 grams that provide services or assistance targeted to
4 the aged and individuals with disabilities.

5 “(4) INVOLVEMENT OF INDIVIDUALS.—The
6 qualified case manager shall be responsible for ar-
7 ranging for the involvement of appropriate persons
8 in the comprehensive assessment and development of
9 the plan of care. In addition, the plan of care shall
10 be developed and implemented in close consultation
11 with the individual and individual’s family.

12 “(5) CARE PLAN MONITORING.—The qualified
13 case manager shall monitor the delivery of services
14 to the individual, the quality of care provided, and
15 the status of individual. Periodic reassessments of
16 the status and needs of the individual, and revisions
17 of the care plan, shall be made by the qualified case
18 manager as appropriate. Such reassessments shall
19 be conducted not less than every 6 months. If the
20 individual is no longer eligible for benefits as a re-
21 sult of improved health conditions or death, the
22 qualified case manager, in consultation with the in-
23 dividual’s primary medical care provider, shall dis-
24 charge the case.

1 “(6) QUALIFIED CASE MANAGER.—In this sec-
2 tion, the term ‘qualified case manager’ means a per-
3 son or entity which—

4 “(A) provides case management services to
5 an individual who is eligible for home and com-
6 munity-based services;

7 “(B) is not a relative of the individual re-
8 ceiving such case management services;

9 “(C) has experience in assessing individ-
10 uals’ functional and cognitive impairment;

11 “(D) has experience or has been trained in
12 establishing, and in periodically reviewing and
13 revising, individual community care plans, and
14 in the provision of case management services to
15 individuals who are eligible for home and com-
16 munity-based services under this section;

17 “(E) completes the individual care plan in
18 a timely manner and reviews and discusses new
19 and revised individual care plans with the indi-
20 vidual or such individual’s representative or
21 both; and

22 “(F) meets such other standards estab-
23 lished by the Secretary or the State which may
24 include standards which assure—

1 “(i) the quality of the case manage-
2 ment services; and

3 “(ii) that individuals whose home and
4 community-based services such person or
5 entity manages are not at risk of financial
6 exploitation due to such a manager.

7 “(7) RELATIVE DEFINED.—In this section, the
8 term ‘relative’ means an individual bearing a rela-
9 tionship to another individual which is described in
10 paragraphs (1) through (8) of section 152(a) of the
11 Internal Revenue Code of 1986.

12 “(e) TYPES OF PROVIDERS AND REQUIREMENTS FOR
13 PARTICIPATION.—

14 “(1) IN GENERAL.—The State plan shall speci-
15 fy—

16 “(A) the types of services eligible to par-
17 ticipate in the program under the plan; and

18 “(B) any requirements for participation
19 applicable to each type of service provider.

20 “(2) SERVICE PROVIDER DEFINED.—In this
21 section, the term ‘service provider’ means a provider
22 who is licensed under State law or who meets other
23 criteria as the Secretary or State may specify.

24 “(f) COVERED SERVICES.—

1 “(1) IN GENERAL.—In this section, the term
2 ‘covered services’ includes—

3 “(A) case management;

4 “(B) adult day services;

5 “(C) habilitation and rehabilitation serv-
6 ices;

7 “(D) home health care;

8 “(E) respite services; and

9 “(F) hospice services.

10 “(2) DELIVERY OF SERVICES.—Subject to the
11 limits in subsection (g), covered services may be de-
12 livered in an individual’s home, a range of commu-
13 nity residential arrangements, or outside the home.

14 “(3) AMOUNT, SCOPE, AND DURATION.—In es-
15 tablishing the amount, scope, and duration of serv-
16 ices required to be provided, covered services shall be
17 treated as required services under this title.

18 “(g) EXCLUSIONS AND LIMITATIONS.—

19 “(1) IN GENERAL.—The following are specifi-
20 cally excluded from coverage under this section:

21 “(A) Room and board.

22 “(B) Items or services otherwise covered to
23 the extent that such items or services are cov-
24 ered under an insurance plan or program other
25 than a State health program.

1 “(C) Services provided to an individual
2 who otherwise would be institutionalized in a
3 nursing facility or intermediate care facility for
4 the mentally retarded, unless the State, or if
5 delegated, the qualified case manager reason-
6 ably estimates (under methods specified by the
7 Secretary) that the cost of covered services
8 under this section would be lower than if the in-
9 dividual were so institutionalized.

10 “(D) Services specified in the plan of care
11 which are not specified as covered services
12 under subsection (f)(1).

13 “(2) TAKING INTO ACCOUNT INFORMAL
14 CARE.—A State plan may take into account, in de-
15 termining the amount and array of services made
16 available to covered individuals with disabilities, the
17 availability of informal care.

18 “(h) MAINTENANCE OF EFFORT.—The State plan
19 must provide assurances that, in the case of an individual
20 receiving medical assistance for home and community-
21 based services under this title as of the date of the enact-
22 ment of this section, the State will continue to make avail-
23 able (either under this title or otherwise) to such individ-
24 ual an appropriate level of assistance for home and com-
25 munity-based services, taking into account the level of as-

1 sistance provided as of such date and the individual's need
2 for home and community-based services.

3 “(i) QUALITY ASSURANCE AND SAFEGUARDS.—

4 “(1) QUALITY ASSURANCE.—The State shall
5 ensure and monitor the quality of services, includ-
6 ing—

7 “(A) safeguarding the health and safety of
8 individuals with disabilities;

9 “(B) establishing minimum standards for
10 care managers and providers and enforcing
11 those standards,

12 “(C) establishing the minimum competency
13 requirements for provider employees who pro-
14 vide direct services under this section and how
15 the competency of such employees will be en-
16 forced;

17 “(D) obtaining meaningful consumer
18 input, including consumer surveys that measure
19 the extent to which participants receive the
20 services described in the plan of care and par-
21 ticipant satisfaction with such services;

22 “(E) participation in quality assurance ac-
23 tivities; and

24 “(F) specifying the role of the long-term
25 care ombudsman (under the Older Americans

1 Act of 1965) and the Protection and Advocacy
2 Agency (under the Developmental Disabilities
3 Assistance and Bill of Rights Act) in assuring
4 quality of services and protecting the rights of
5 individuals with disabilities.

6 “(2) SAFEGUARDS.—

7 “(A) CONFIDENTIALITY.—The State shall
8 provide safeguards which restrict the use or dis-
9 closure of information concerning applicants
10 and beneficiaries to purposes directly connected
11 with the administration of the program.

12 “(B) SAFEGUARDS AGAINST ABUSE.—The
13 State shall provide safeguards against physical,
14 emotional, or financial abuse or exploitation in
15 the provision of care management and covered
16 services.

17 “(j) PROVIDER REIMBURSEMENT.—

18 “(1) PAYMENT METHODS.—The State shall
19 specify the payment methods to be used to reim-
20 burse providers and case managers for services fur-
21 nished under the plan. Such methods may include
22 reimbursement on a fee-for-service basis, prepay-
23 ment on a capitation basis, or a combination of
24 these methods. The State, if it chooses, may provide

1 the case manager with authority to negotiate rates
2 with individual providers.

3 “(2) PAYMENT RATES.—The State shall specify
4 the methods and criteria to be used to set payment
5 rates for services furnished under the plan. In addi-
6 tion to any other requirements, such payments must
7 be sufficient to ensure that the requirements of
8 1902(a)(30)(A) are satisfied.

9 “(3) PAYMENT IN FULL.—Except as specified
10 in subsection (d)(2)(B), the State shall restrict pay-
11 ment for covered services to those providers that
12 agree to accept the payment under the plan (at rates
13 established pursuant to subparagraph (2)) as pay-
14 ment in full for services furnished under this section.

15 “(k) APPROVAL OF STATE PLAN AMENDMENTS.—
16 Each state shall take whatever action is necessary to have
17 an amendment to its State plan under this title approved
18 by October 1, 1996, that implements this section for that
19 State not later than October 1, 1997, except that where
20 an Act of the State legislature is necessary to effectuate
21 such State plan amendment and said legislature is not in
22 session as of the date of the enactment of this section,
23 the State shall have said amendment approved not later
24 than 6 months after the commencement of the session of
25 its legislature that begins immediately subsequent to such

1 date of enactment, if such date is later than October 1,
2 1996.”.

3 **SEC. 602. INCREASED RESOURCE DISREGARDS FOR NURS-**
4 **ING FACILITY RESIDENTS.**

5 Section 1902(a)(10) of the Social Security Act (42
6 U.S.C. 1396a(a)(10)) is amended—

7 (1) by striking “and” at the end of subpara-
8 graph (F); and

9 (2) by inserting after subparagraph (F) the fol-
10 lowing new subparagraph:

11 “(G) that, in determining the eligibility of
12 any individual who is an inpatient in a nursing
13 facility or intermediate care facility for the
14 mentally retarded, in the case of an unmarried
15 individual, the first \$12,000 of resources shall
16 be disregarded.”.

17 **TITLE VII—ASSET TRANSFERS**

18 **SEC. 701. TRANSFERS OF ASSETS.**

19 Section 1917(c)(1)(B)(i) of the Social Security Act
20 (42 U.S.C. 1396p(c)(1)(B)(i)) is amended to read as
21 follows:

22 “(B)(i) The look-back date specified in this sub-
23 paragraph is a date that is 60 months before the
24 date specified in clause (ii).”.

1 **SEC. 702. TREATMENT OF CERTAIN TRUSTS.**

2 Section 1917(c)(2) of the Social Security Act (42
3 U.S.C. 1396p(c)(2)) is amended by adding at the end the
4 following new flush sentences:

5 “In order for the income or assets of an income cap trust,
6 nonprofit asset trust or other such trust arrangement to
7 be exempt under this paragraph, the trust must be irrev-
8 ocable and all amounts remaining in the beneficiary’s ac-
9 count must be paid to the State upon the death of the
10 beneficiary. For purposes of this section, the term ‘trust’
11 shall not include a personal service contract annuity for
12 a family member within the 60-month period even if such
13 transfer is for fair market value. The Secretary shall pro-
14 hibit, by regulation, the use of family limited partnerships
15 to convert available assets into an exempt status; pur-
16 chases of interests in third-party assets for the purpose
17 of rendering otherwise includable assets unavailable, and
18 not subject to liens; and purchase of care services agree-
19 ments for past services by family members to reduce
20 countable assets.”.

21 **SEC. 703. EFFECTIVE DATE.**

22 The amendments made by this title shall be effective
23 January 1, 1995.

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